S. Hrg. 100-880

DELAY IMPLEMENTATION OF A CERTAIN RULE AFFECTING THE PROVISION OF HEALTH SERVICES BY THE INDIAN HEALTH SERVICE

HEARING

BEFORE THE

SELECT COMMITTEE ON INDIAN AFFAIRS UNITED STATES SENATE

ONE HUNDREDTH CONGRESS

SECOND SESSION

ON

S. 2382

TO DELAY THE IMPLEMENTATION OF A CERTAIN RULE AFFECTING THE PROVISION OF HEALTH SERVICES BY THE INDIAN HEALTH SERVICE

JUNE 21, 1988
WASHINGTON, DC

U.S. GOVERNMENT PRINTING OFFICE
89-846 WASHINGTON : 1988

For sale by the Superintendent of Documents, Congressional Sales Office
U.S. Government Printing Office, Washington, DC 20402

S411-5

SELECT COMMITTEE ON INDIAN AFFAIRS

DANIEL K. INOUYE, Hawaii, *Chairman*
DANIEL J. EVANS, Washington, *Vice Chairman*

JOHN MELCHER, Montana	FRANK H. MURKOWSKI, Alaska
DENNIS DECONCINI, Arizona	JOHN McCAIN, Arizona
QUENTIN N. BURDICK, North Dakota	
THOMAS A. DASCHLE, South Dakota	

ALAN R. PARKER, *Staff Director*
PATRICIA M. ZELL, *Chief Counsel*
JOE MENTOR, Jr., *Minority Counsel*

CONTENTS

Page

S. 2382, text of 2

Statements:

- Bibo, Gerald, President, Northern Montana Hospital, Havre, MT; Chairman, Board of Trustees, Montana Hospital Association, Helena, MT 13
- Johnson, Dr. Emery, former director, Indian Health Service 19
- Melcher, Hon. John, U.S. Senator from Montana 1
- Old Person, Earl, chairman, Blackfeet Tribal Council, Browning, MT 25
- Rhoades, Dr. Everett R., Director, Indian Health Service 6
- Taylor, Jonathan L., principal chief, Eastern Band of Cherokee Indians, on behalf of the United South and Eastern Tribes, Inc., Nashville, TN ... 27
- Whitecrow, Jake, executive director, National Indian Health Board, Denver, Co 16

APPENDIX

Prepared statements:

- Bibo, Gerald 70
- Johnson, Dr. Emery 86
- Melcher, Hon. John, U.S. Senator from Montana 31
- Old Person, Earl 95
- Rhoads, Dr. Everett R. (with attachments) 34
- Taylor, Jonathan L. (with attachments) 100
- Whitecrow, Jake (with attachments) 79
- White Tail Feather, Raymond, Chairman, Assiniboine and Sioux Tribes, Fort Peck Indian Reservation 108

DELAY IMPLEMENTATION OF A CERTAIN RULE AFFECTING THE PROVISION OF HEALTH SERVICES BY THE INDIAN HEALTH SERVICE

TUESDAY, JUNE 21, 1988

U.S. SENATE,
SELECT COMMITTEE ON INDIAN AFFAIRS,
Washington, DC.

The committee met, pursuant to notice, at 10:06 a.m., in room 485, Russell Senate Office Building, Hon. John Melcher (acting chairman of the committee) presiding.

Present: Senators Melcher, Burdick, Daschle, Murkowski, and McCain.

Staff present: Clara Spotted Elk.

STATEMENT OF HON. JOHN MELCHER, U.S. SENATOR FROM MONTANA

Senator MELCHER. The committee will come to order.

This morning we are meeting in a public hearing on S. 2382. The subject before us is eligibility for IHS services, and that is a pretty fundamental issue among Indians and their families.

Health care from the Indian Health Service, should be made as accessible as possible to Indian people. I find that proposed regulations would interfere with that if they were to go into effect.

S. 2382 is a bill I introduced a few weeks ago to prevent IHS from implementing the regulation which would change the criteria under which Indians are eligible to receive health care from the Indian Health Service. I believe the bill is necessary because the regulations that have been developed would cut many Indians off from IHS, which is the only source of medical care for many people on reservations.

Under the IHS rule, three changes would be made. Non-tribal members would be cut off from care. Contract health care services would be extended to all members of federally recognized tribes living off the reservation in health care service areas. Finally, people would have to formally apply for services.

So, it doesn't come as any surprise that the tribes and Alaska Native villages are vigorously opposed to the regulation. They have asked for a moratorium and a study which will provide more input from them and more information.

S. 2382 would accomplish those objectives and also require IHS to actively consult with Indian people about any changes in eligibility which are proposed.

[The text of S. 2382 follows:]

II

100TH CONGRESS
2D SESSION

S. 2382

To delay the implementation of a certain rule affecting the provision of health services by the Indian Health Service.

IN THE SENATE OF THE UNITED STATES

MAY 12 (legislative day, MAY 9), 1988

Mr. MELCHER introduced the following bill; which was read twice and referred to the Select Committee on Indian Affairs

---

A BILL

To delay the implementation of a certain rule affecting the provision of health services by the Indian Health Service.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. The final rule published in the Federal Register on September 16, 1987, by the Health Resources and Services Administration of the Public Health Service of the Department of Health and Human Services, relating to eligibility for the health care services of the Indian Health Service, shall not take effect before the day that is three years after the date of enactment of this Act, and no action may be taken before such day to implement or administer such rule or to prescribe any other rule or regulation that has a similar effect.

SEC. 2. During the three-year period described in section 1, the Indian Health Service shall provide services pursuant to the criteria for eligibility for Indian Health Services in effect prior to September 16, 1987.

SEC. 3. (a) The Secretary of Health and Human Services, acting through the Indian Health Service, shall conduct a study to determine the impact that the final rule described in section 1 or any other proposed rules which would change eligibility criteria for Indian Health Services.

(b) The study conducted under subsection (a) shall include—

(1) the full participation and consultation which American Indian and Alaskan Native tribal governments, and representatives of urban Indian health care programs;

(2) statistics for each of the Indian Health Service Areas on the number of Indians who are currently eligible for the services of the Indian Health Service;

(3) statistics for each of the Indian Health Service Areas on the number of Indians who would be eligible for such services if the final rule described in section 1 or any alternative rules changing eligibility were implemented;

(4) consideration of the financial impact of such final rule or any other proposed rule on the contract health care budget and on the clinical services budget of the Indian Health Service;

(5) consideration of the health status, cultural, social, and economic impact on Indian reservations and urban Indian populations if the proposed rule or any other rule changing the eligibility criteria were to be implemented;

(6) consideration of the alternatives, if any, that would be available to those Indians who would not be eligible for such services by reason of any such final rule which would change the eligibility criteria for Indian Health Service services; and

(7) consideration of the program changes that the Indian Health Service would be required to make if the eligibility requirements for such services that are in effect on the date of enactment of this Act were modified.

(c) After complying with the requirements of this section, the Secretary of Health and Human Services shall submit to the Congress a report on the study twenty-four months after the date of enactment of this Act.

(d) Before submitting to the Congress the report on the study conducted under this section, the Secretary of Health and Human Services shall provide Indian tribes, Alaska Native villages, and urban Indian health care programs an opportunity to comment on the report and shall incorporate the comments on such Indian groups into the report.

SEC. 4. There are hereby authorized to be appropriated such sums as are necessary to carry out the purposes of this Act.

○

[Prepared statement of Senator Melcher appears in appendix.]

Senator MELCHER. Senator McCain, do you have an opening statement?

Senator MCCAIN. No; thank you, Mr. Chairman.

Senator MELCHER. Our first witness will be Dr. Everett Rhoades who is the Director of the Indian Health Service in Rockville.

There is a vote at 10:30. It will interfere with this hearing. All of our witnesses must be very brief, and we will take the prepared testimony and make it part of the record, but we simply do not have time to have lengthy discussion.

Please proceed, Dr. Rhoades.

STATEMENT OF EVERETT R. RHOADES, M.D., DIRECTOR, INDIAN HEALTH SERVICE; ACCOMPANIED BY RICHARD McCLOSKEY, DIRECTOR, DIVISION OF LEGISLATION AND REGULATIONS

Dr. RHOADES. Thank you, Mr. Chairman and members of the committee.

My name is Everett Rhoades. I am the Director of the Indian Health Service. I am accompanied today by Mr. Richard McCloskey, who is the Director, Division of Legislation and Regulations.

I welcome the opportunity to discuss further the question of eligibility for Indian Health Services. I will abbreviate my remarks, but I think there are a number of points that must be made, Senator Melcher.

The basic authority for the provision of services to Indian people resides in the Snyder Act of 1921 which states that the Secretary shall expend funds that Congress may from time to time appropriate for the relief of distress and conservation of health of "Indians throughout the United States." The Snyder Act does not define eligibility requirements or the details of any particular program, that having been left to departmental regulations and subsequent Acts of Congress.

The current eligibility regulations require an individual to be "of Indian descent, belonging to the Indian community served by the local facilities and programs." Over the course of history, the Indian Health Service has construed these words liberally and appropriately, I believe, to include anyone who could reasonably be regarded as an Indian, regardless of degree of Indian ancestry or tribal affiliation.

The Indian Health Service has interpreted these regulations to authorize it to provide services to any otherwise eligible Indian who presented himself or herself to an Indian Health Service facility. With the growth in the size and importance of contract health care, however, a new problem was introduced having to do with an additional need to define who was on or near a reservation.

This problem was difficult enough that it actually led to a law suit and subsequent promulgation in 1978 of additional regulations governing eligibility for contract health services, including now, for the first time, a definition of "on or near" so that an individual, in addition to being of Indian descent and meeting the earlier criteria, also now had to reside in a certain location.

However, we had two sets of criteria for eligibility for Indian health services, and this was the only change affecting Indian eligibility in the 32 years of the existing current eligibility regulations.

There has been increasing dissatisfaction expressed from all quarters, I would say, with the existing regulations and a growing concern that the Indian Health Service resources were being directed beyond what was considered to be the intended scope of the program.

When Indian health services were provided on a reservation or in areas primarily inhabited by closely knit Indian populations, it was fairly readily apparent who belonged to the community to be served. However, with shifts in population away from reservations, increasing intermarriage, greater urbanization of traditionally rural areas with a resulting increase in Indian and non-Indian mix of population, and the expansion of services to new areas through contract health care, individuals belonging to the Indian community were no longer as readily identifiable as in former times.

All of these problems have been made worse by the rapid increase in the cost of medical care, the continued improvement in both the quality and accessibility of Indian health services, and increased acceptance by the Indian community of the Indian Health Service program.

Put in the simplest terms, the question now before us is, how many real Indians or Indians in the original intent of Congress is the Indian Health Service serving and do the current regulations still provide effective and understandable criteria both for the Indian people and those who administer the program?

I need to emphasize further that Congress itself recognized this problem 6 years ago when the 97th Congress directed the Indian Health Service to address the issue of an expanding service population in terms of defining who is or who should be eligible for Indian health services.

The process that has been followed in the last 6 years has been an intricate, complicated, and, I believe, thorough examination of the question beginning in June of 1983, 5 years ago, with two Federal Register notices, published with solicited comments. We received a total of 242 responses to that 5 years ago, 28 from tribal governments, 4 from tribal organizations, and 15 from other Indian organizations. There were 191 from individuals.

In general, the 51 tribes and other organizations responding supported the use of a blood quantum requirement for Indian Health Service eligibility, and most of those who supported a blood quantum requirement said that it should be one-fourth or more.

Three years after that, in June of 1986, the Department published a notice proposing changes in the Indian Health Service eligibility regulations, and a copy of this notice was sent to every federally recognized tribe and interested Indian organization with a comment period originally for 120 days, expanded to 150 days at the request of some Alaskan communities.

During that comment period, the Indian Health Service sponsored over 120 public meetings, some with translators in attendance. All were locally scheduled and advertised, resulting in over 10,000 pages of transcripts, all of which were made available to this committee.

In addition, we received over 11,000 submissions from 16,000 commenters, ranging from individuals to 172 tribes. Each issue and each suggestion raised was carefully considered, and the final rule represented a careful consideration and balancing of all of the views presented.

So, the new regulation, in fact, was a result of a process that took over four years.

As you point out, we are well aware that there is a great deal of opposition being expressed now throughout the Indian community against implementation of the new regulation, as expressed to me by a group of Indian attendees at a recent consultation meeting sponsored by the Indian Health Service in Nashville. As I promised to the tribes there, in fact, I have forwarded their concerns and views to the Assistant Secretary for Health.

The basic issue, it seems to me, at the present time, revolves around the question of tribal membership. Three issues have surfaced which I would like to mention briefly.

First, a number of tribes have expressed concern that they do not have enrollment systems. This same concern has been expressed by the Bureau of Indian Affairs.

I just want to point out that the regulations in no way call for any enrollment system. An enrollment system would be acceptable. However, the regulation is very broad and states that membership can be demonstrated "as prescribed by the charter, articles of incorporation, or other legal instruments, or traditional processes of the tribe." Any method by which the tribe identifies its members is acceptable to the Indian Health Service.

Second, concern has been expressed with the method of documenting tribal membership. I want to put on the record that there was never any intent by the Indian Health Service to put the Bureau into a position of determining tribal membership either. In fact, we agree this would have gone against the entire concept of emphasizing tribal control.

The purpose was simply to permit the Bureau to act where it was authorized and required to act by legislation and so forth.

Third, we have become aware that a number of tribes are considering expanding their membership requirements, in some cases, expansion of membership solely for the receipt of health services and will be accomplished by establishing different categories of tribal membership.

This would appear to me to be within applicable laws, but I am very concerned about the long-term consequences of such actions.

You, in your opening remarks, expressed the concern that the purpose of the rule was to reduce the number of eligible Indians and that the rule will increase the demand for services.

Those concerns are, in fact, partly correct, but the main purpose is responding to the ever increasing need to establish some better basis for the continued rationing of medical care while, at the same time, attempting to meet the requirements of the law in relation to the establishment of equity in the allocation of resources, someone has to define to whom those resources go; otherwise, we would be in a totally chaotic, untenable position.

We have estimated that probably 125,000 Indians will become eligible for care under the new tribal membership requirement. We have reason to believe that there may be that many persons of Indian descent who are receiving care now who are not members of federally recognized tribes.

The growing demand for Indian health services, as evidenced by the expanding service population, clearly will continue to outstrip the supply of medical services that can be provided by any amount of Indian Health Service resources that can rationally be contemplated. This has greatly exacerbated the pressure on the Indian Health Service to find ways, as I mentioned, to ration contract health care to the Indian population in ways that meet the often conflicting demands for more health care, equity in the distribution of resources, and the fundamental mission to raise the health status of Indian people to the highest possible level.

I am not in a position to make a declaration that the Indian Health Service believes that only it knows what the proper criteria should be. I believe the consultation has been very extensive, as evidenced by the record. We certainly welcome the continued interest on the part of the United States Congress where we believe probably the basic responsibility lies in any case.

I would certainly welcome any improvements to the provision of health services to Indian people and ways to meet these conflicting demands. I believe that after five years, a reasonable period of time for deliberation, in fact, has been allocated to this, and I would hope that Congress would take that into account as it continues to deliberate also on this very perplexing problem.

Mr. Chairman, thank you for the opportunity to testify this morning, and I would be glad to try to answer any questions you might have.

[Prepared statement of Dr. Rhoades appears in appendix.]

Senator MELCHER. Doctor, you state that in rationing health care, there would be 125,000 Indians now served by the Indian Health Service that would not be eligible. Is that correct?

Dr. RHOADES. We are rationing health care to all Indian people, not just to a certain group. That is not a new phenomenon. The Indian Health Service has always rationed care in one form or another.

With the revolution that is going on in the way medical care is delivered in this country and with the revolution that is going on technologically and from a standpoint of the financing of medical care, the pressures that are being exerted are much more acute.

So, what we are seeking are ways that the care can be rationed in a more reasonable fashion. That is really what the search is about.

Senator MELCHER. You stated that 125,000 Indians who are now eligible for Indian Health Service would not be eligible under the regulations. Is that correct? Did I understand you correctly?

Dr. RHOADES. No; I didn't mean to imply that.

Senator MELCHER. It has been stated several times by the Indian Health Service. I thought I heard you repeat it. You said 125,000 would be eligible who are not now eligible, but, likewise, 125,000 who are now receiving Indian Health Service may not be eligible.

Dr. RHOADES. Yes, sir; that is correct. I do not know the exact number.

Senator MELCHER. Who are they, the ones that are now eligible that won't be eligible after the regulations are imposed? Who are they?

Dr. RHOADES. All of those persons who claim Indian descent in this country but, in fact, do not belong to a federally recognized tribe would no longer be eligible.

Senator MELCHER. Well, where do they live?

Dr. RHOADES. They live scattered across the United States. They tend to be aggregated in certain areas.

Senator MELCHER. I think that is a problem right there. Here is a regulation that is going to change the health status, that is, the eligibility for health care, for some 125,000 Indian people or Alaskan Natives, and we don't know who they are. We have some pretty good ideas of who they might be, and that is what bothers us, because we don't think you have any studies undertaken during this 5 years you are talking about that indicate just who would become ineligible. That bothers us. Do you have any studies?

Dr. RHOADES. We don't have studies in a formal sense, no.

Senator MELCHER. Well, I think now you understand exactly why we are bothered and why Indian tribes are bothered and Alaskan Natives are bothered. That is the purpose of the bill, to establish just exactly what would happen if your regulations were imposed.

Senator Murkowski.

Senator MURKOWSKI. Thank you, Mr. Chairman.

It has been inferred it would have an effect on Natives in the State of Alaska, and I am advised that there are approximately 12,300 Alaska Natives that are currently being served that, if these regulations are initiated, would not be served, because these Natives are neither on the Alaska Native Settlement Claims Act roll nor on village rolls as well.

That leaves us with the reality that if these regulations—if we are going to adopt regulations and they are going to be meaningful, we are going to have to get some control on an enrollment process that is equitable. I am wondering, Doctor, what you suggest that would be, recognizing we have an obligation to take care of these people that are deserving that truly are of Indian descent.

We have in the ANCSA application of enrollment at least one quarter Native. You get into tribal enrollments, and it may vary.

It would seem to me, Mr. Chairman, that there is going to be a need for some uniformity before any regulations can have any meaningful application so you can implement on the basis of fairness.

Dr. RHOADES. Senator, I agree entirely. If Congress did nothing else but provide me some uniformity, then I could begin to deal with the other mandate from Congress, that is, of equity.

As you have already pointed out, tribal membership is outside the ability of the Indian Health Service to deal with—particularly should a tribe say well, we are going to expand our membership to include a category that will be entitled to get service from the Indian Health Service but who can't vote in our elections or otherwise participate in our tribe.

Senator MURKOWSKI. Well, Dr. Rhoades, let's carry that on a moment. If they were going to expand that membership, the criteria would be what for inclusion? Would it be simply their decision to expand it, or would it have to meet federally approved criteria? An eighth Indian or married to an Indian?

Dr. Rhoades. The proposed regulations are very clear. That resides within the authority of that tribe. The Indian Health Service will not dictate that.

Senator Murkowski. So, could an Indian tribe simply take in a group of Caucasians that could not vote and include them in their health membership roll?

Dr. Rhoades. I believe that could happen, yes.

Senator Murkowski. Well, what would you suggest be done to try to bring some corrective input into this thing without the tribes losing their individual status as far as the application of not self-government exactly but the will of the tribe to do as it sees fit in general ways?

Dr. Rhoades. Senator Murkowski, let me correct my answer. In fact, a non-Indian would not become eligible under the proposed regulations. Only a person of Indian descent, but there is a large volume of individuals like that which would greatly expand the demand.

The question of the expandability of the demand is one that has to be dealt with. In 1977, for example, in Oklahoma, a criteria for a one-fourth degree blood quantum was dropped, with a 30 percent increase in the demand, and the increase in demand on services in the Oklahoma area where it, obviously, would be most magnified, is growing at a rate greater than that for the rest of the population and clearly can utilize all of our resources for that.

Over 125 or thereabout of the tribes who responded said we have to have tribal membership as the criterion. At least 125 of those tribes already have a blood quantum requirement for membership in their tribes.

There is incredible diversity across this country in relationship to tribal membership, and therein lies the weakness of using tribal membership. I maintain we cannot have equity on the one hand, as I understand it, and a lack of uniformity on the other hand, as you have pointed out.

Senator Murkowski. What do you suggest, Doctor?

Dr. Rhoades. The best solution, in my opinion, given the constraints that are placed upon us, is to say that the Indian Health Service will provide services to those individuals who belong to members of federally recognized tribes. That leaves a great deal to be desired.

Senator Murkowski. Let me pursue that for a moment. Let's take the case of the Tsimpsians that you and I are familiar with in Metlakatla. Let's assume that various Tsimpsians several years ago abandoned their connections and no longer live on the reservation. Yet, they are distributed throughout southeastern Alaska, but they are not Haidas and they are not Tlingits which are legitimately enrolled as tribal entities that would warrant health service. Yet, these people are Indian people, Indian Americans, Indian Alaskans.

If they can't get enrolled as Tlingit-Haidas and they no longer live on the reservation and qualify as Tsimpsians, then where do they go? How do we take care of those people?

Dr. Rhoades. That is a problem.

Senator MURKOWSKI. I know, but you deal with it, and you are much more likely to come up with responsible suggestions than those of us sitting back here.

Dr. RHOADES. The other side of that same question——

Senator MURKOWSKI. All right, but be sure and answer my question. How do we take care of that Indian who is no longer welcome in the Tsimpsian and he is not a Tlingit-Haida?

Dr. RHOADES. There are two aspects to that problem. The Indian Health Service cannot fix those kinds of questions of tribal membership. It lies within the jurisdiction of Congress, in my understanding, and, in some instances, the Bureau of Indian Affairs can define a federally recognized tribe. That would solve it.

Second is that even if that is solved, we operate under the general guidance of the United States Congress in providing services to Indians on or near reservations. One of the difficulties is that so many of the Indians no longer live on or near reservations. So, we are going to continually have to be striving for ways to equitably allocate those resources and raise the health status of Indian people to the highest possible level.

Otherwise, in order for me to reach those Indians, I have to deny Indians that live on the reservation that are members of federally recognized tribes. One of the things I am a little bit concerned about is that the questioning thus far this morning does not take into account those thousands of Indian people that can't get into the facilities right now who are full blood Indians living on a reservation with close socioeconomic ties to the reservation because we have so diluted out the services.

I say, quite appropriately, historically, that somebody has to speak for that group of disenfranchised Indians as well.

Senator MURKOWSKI. Well, that still doesn't absolve us of the obligation to take care of those Indians that qualify as Indians and are no longer on reservations. Would it be possible to set up kind of a catch-all in those States where we have a prominent Indian population? As you recall, in Alaska, we set up a thirteenth regional corporation as a catch-all for all those who lived in Oklahoma, New York, Washington, or wherever.

Would it be conceivable to set up some kind of a tribal recognition for those that do not belong to any organized tribe for one reason or another? Because we still have an obligation to take care of them as much as we do, as I see it, the Indian who is in a qualified tribe.

We have a vote on, and Senator McCain and I are going to have to leave, and I assume we are going to have to recess the hearing, but if you could just——

Dr. RHOADES. Do you want me to respond before you go?

Senator MURKOWSKI. Please.

Dr. RHOADES. I am sure that criteria could be established. It sounds like the desire would be to include everybody that could conceivably be included, and that is what we are struggling with.

Senator MURKOWSKI. Well, I think we have an obligation to take care of all those who qualify as opposed to whether or not they are desirous of wanting to be included. I think we have an obligation. We have to have a niche for them somewhere. Now, if they don't choose to do so, that is their own business.

Dr. RHOADES. I am sure that such could be constructed, but I just would like to point out that in order to do that, an increasing number of individuals would be denied services where they reside now. There is a terrible dilemma there.

Senator MURKOWSKI. I still don't think that absolves us of the obligation.

Dr. RHOADES. Oh, I agree with that.

Senator Murkowski (acting chairman). Thank you.

I will recess the hearing pending the call of the first member to come back.

[Recess taken.]

Senator MELCHER. The committee will come to order.

Thank you very much, Dr. Rhoades. There may be some further questions later on or we may submit some in writing. We appreciate your appearance here today.

Dr. RHOADES. Thank you.

Senator MELCHER. Our next witnesses will be Gerald Bibo, President of the Montana Hospital Association; Jake Whitecrow, Executive Director of the National Indian Health Board; and Dr. Emery Johnson, former Director of the Indian Health Service.

Please proceed.

STATEMENT OF GERALD BIBO, PRESIDENT, NORTHERN MONTANA HOSPITAL, HAVRE, MT; AND CHAIRMAN OF THE BOARD OF TRUSTEES, MONTANA HOSPITAL ASSOCIATION, HELENA, MT

Mr. BIBO. Mr. Chairman, as Chairman of the Board of Trustees of the Montana Hospital Association and as President of the Northern Montana Hospital in Havre, MT, we have some concern with regard to the manner in which the rules and regulations were being suggested to be put in place and are certainly in support of your S. 2382 for delaying this for three years to study financial, social, and cultural implications of the proposed rules.

In the State of Montana, as you well know, which is one of the largest land mass States within the Union, we have 11 contract health hospitals of which our hospital is one. We have 7 Indian reservations and 3 IHS hospitals, one in Fort Belknap near us, one in Browning, and the Crow Agency in the southeastern part of the State. Of the contract hospitals, 7 of the contract hospitals average less than 40 beds in size and the 4 remaining average 167 beds, the smallest of which is ours which is 120 beds.

Since the final rules which would be put in place on September 16, 1988 have an affect on small hospitals, as everyone knows, in the past year, DRG's have come to the Indian Health Service and to those contract hospitals that are paid now based on DRG's which, for all practical purposes, is discounted charges in providing services to the Indians.

The DRG's place risk upon the hospitals and the providers. While that sounds good, it depends upon the volumes at different times of the services as to how it affects the individual facility or provider. These changes in traditional composition payments leave the hospital with no choice but to shift costs which means an increase in bad debts, an increase in charity, and affects various hospitals differently, depending on their particular location within the State and the makeup of their constituency surrounding their hospitals.

The bad debts and write-offs in hospitals in Montana have increased from what was 15 to 20 percent in more recent years to 25 to 30 percent of the total revenues of the hospital. In Poplar, for example, a 22-bed facility on the Fort Peck Reservation, about 90 percent of their care is IHS, Medicare, and Medicaid and is DRG utilized.

You might say how anything affects an individual facility's chance to be competitive, but in this particular case, as an instance, there is only 10 percent left for consideration in terms of increasing your charges to cover your costs. When 3 percent of that 10 percent is bad debts or charity you really have, in that facility, 7 percent of those who can pick up any additional charges in terms of continuing that facility.

So, in facilities like that, small changes can make and have a big impact on those particular hospitals. In the Poplar instance, for example, charges would have to be increased $14 to realize $1 of additional money for the facility.

What happens, then, if facilities like that close? Well, obviously, the Indians would have to travel larger distances or contract elsewhere to get the services involved. Now, if these individuals no longer have the benefit of Indian Health Service for their health services, you might say, well, then, other resources are Medicaid. In the State of Montana, 70 percent of Medicaid comes from the Federal Government, 30 percent from the State, and the State is having one heck of a time coming up with the funds to make the 30 percent.

If then an individual might be able to be employed would be another way of that individual getting health services. However, on the two tribes near our facility at Fort Belknap and Rockyboy, roughly 75 percent of the people are unemployed. So, saying that that is a new resource is not very probable unless there are new jobs that become available to the Indian population.

Even with commercial insurance, there are services that would not, depending on the employer, necessarily be provided or paid for. For example, eye glasses, hearing aids, diabetic clinics, things of this sort are not normally a part of an employer's health insurance package. So, these additional services would be denied to these folks.

We then would have to pick up the difference ourselves as a health care provider or facility which increases our write-offs. Rural hospitals and the problem of the Indian Health Service is somewhat alike in that the distances involved between those that are served and the facilities are such that survival is becoming of key concern in these days of less payment for services.

As contract hospitals and, in our particular case, there are some things that may be able to be done which we suggested in our contracting with the Indian Health Service, and bear in mind those that services are rendered in that did not elect to contract, services are paid for at 100 percent reimbursement to the facility. We are one of the facilities, along with the other 10, that are elected to contract with Indian Health Service.

Accompanying our contracting, I would not like to leave you with the feeling that the only concern is with regard to economics as far as the providers are concerned. We have a concern for the Indian health status and access to services to the Indian people.

We feel our private and Indian Health Service physicians should determine the level of services to be provided and that they should be provided locally and that planning for services needs to include contract providers and physicians in order for efficiencies to be achieved. You can't plan in a vacuum.

We have started a dialogue between ourselves and the tribes neighboring our community with regard to this contract and concern for this particular set of rules that are being put in place. In a relationship between eligibility and the financial health of contract facilities, we suggest in return for our cooperation that the Indian Health Service consider that, too.

We can't say exactly what the impact of the rules will be. We can't find out exactly how many would be affected. However, in consultation with the chiefs of the two tribes adjacent to our facility, I find that we have 300 that would not be eligible from Rockyboy and 1,000 from Fort Belknap. So, that is roughly 25 percent of those adjacent to our facility.

We have now contracted to have DRG's determined with some stop loss provisions, payment for services rendered at our facility. Obviously, then, if these people become ineligible and alternate resources are not available, the burden to provide the care becomes that of the provider, and that does affect our ability to be competitive in providing health services in our region which means then, John, your son and his wife when they came to our hospital would pay a higher price for the services when their baby was delivered than is currently the case which puts us in competition with other hospitals in the State that do not have as high a proportion of Indian Health Service patients, Medicare patients, and Medicaid patients.

In short, I don't know how it was stated that the potential of reaching the highest level of health care services for Indians was one of the goals. I would suggest that this change will not reach that goal and that this change could have a bearing on the smallest facilities in Montana as to whether they will be able to survive. It is one more thing in terms of lack of additional funds for funding of health services.

It could very well, in some areas, affect access to services, because the contracting provision alone has already created access problems to certain of the Indian tribes in our State, and it will obviously affect the quality of services if the moneys are not available to maintain the same services we have been able to provide in the past.

In summary, we support the bill. We think there are so many unknowns yet to be realized. The actual numbers of people affected and the social concerns with those people should be of concern, and that we try to plan together to be able to serve these people and use this 3-year period to put those kinds of planning things in effect.

I know that adjacent to us, they are planning a new clinic between BIA, IHS, and what have you. On occasion, we are not made privy to what is going on. I think there are efficiencies that can be effected, and those kinds of negotiations could be going on during this period when we are trying to determine exactly how many people are eligible and how we take care of them.

I would be glad to answer any questions you might have. I appreciate the opportunity to visit with you, the particulars, of course, I think you have a copy of or at least they were sent in earlier.

[Prepared statement of Mr. Bibo appears in appendix.]

Senator MELCHER. Thank you, Mr. Bibo.

Yes, we do have your statement, and we will have some questions after we hear from the other two witnesses on the panel.

Jake, we will hear from you now and see what the views are of the National Indian Health Board.

STATEMENT OF JAKE WHITECROW, EXECUTIVE DIRECTOR, NATIONAL INDIAN HEALTH BOARD, DENVER, CO

Mr. WHITECROW. Thank you, Mr. Chairman.

I am Jake Whitecrow, Director of the National Indian Health Board. I also serve as the co-chairman of the Health and Human Resources Committee of the National Congress of American Indians. I am member of the Quapaw and Seneca-Cayuga Tribes of Oklahoma. In the 1970's, I served as a commissioner in the American Indian Policy Review Commission and have spent more than 30 years of my life in the field of Indian affairs working from the tribal standpoint.

On behalf of the National Board of Directors, I wish to express my appreciation to this committee for the opportunity to express our views on S. 2382 which addresses the issue of eligibility for health care funded by the Indian Health Service. The National Indian Health Board offers its full support for S. 2382, and we urge that this committee seek prompt passage for this important piece of legislation in order to assure that health services continue to be provided to all American Indians and Alaska Natives that presently qualify for such care.

Over the past 8 years, Indian tribes have been forced to endure a series of efforts designed to reduce the scope of services and programs available to Indian people. Nowhere has this effort been more pronounced than in the area of Indian health care where we have seen repeated attempts to reduce or eliminate services that are essential to the provision of quality medical care to our people.

If not for the support of Congress and, in particular, the work of this committee, the Indian health care system as we know it would surely have been dismantled, and the remarkable progress that has been achieved in improving the health status of our people over the past 30 years would have been reversed.

The most striking example of these proposals to undermine the Indian health program is the issue before this committee today, the effort to redefine who is eligible for health care services funded by the Indian Health Service. In the early 1980's, this recommendation first surfaced in a report issued by the Grace Commission which concluded that 20 percent of the Indian Health Service population could be eliminated through the issuance of new eligibility regulations requiring Indian beneficiaries to be members of federally recognized tribes and have at least one-quarter degree Indian blood.

Such a change, the Commission held, would lead to an annual savings of $60 to $70 million in the Indian Health Service budget.

That initial budget-driven proposal marked the beginning of what has since become one of the most emotional debates in Indian country in recent years. After hundreds of hearings and meetings in Indian communities around the country which led to thousands of comments opposing such changes, the Department of Health and Human Services issued a final rule September 16, 1987, that specified new eligibility criteria for the Indian Health Service. The reaction to these regulations, as you know, Senator, and you have included in your bill, S. 2382, has been a firestorm of protest throughout Indian country.

This protest, in my view, is the result of (1) the perception that the rule is yet another attempt to weaken the Federal Government's trust responsibility to Indian people; and (2) the threat of terminating health services to individual Indians, such as our elders and the handicapped that are most in need and have no other sources of health care; (3) the fact that tribes were not provided adequate data about the potential impact of the rule; and (4) the belief that the new eligibility rule is a direct infringement on the sovereign right of tribal governments to determine for themselves who is eligible for services.

Tribal objections to the new Indian Health Service eligibility rule have been evident at virtually every major regional and national Indian meeting during the past 9 months.

For example, at a recent meeting nationally held in Nashville, Tennessee last month, some 300 tribal representatives voiced unanimous support for a resolution calling for the immediate withdrawal of the eligibility rule and urging congressional intervention to prohibit any further implementation of the new guidelines. That resolution which is included in my written statement as an attachment has been since endorsed by a number of tribal councils nationwide.

One of the most compelling factors that led to the passage of that resolution in Nashville was the clear indication from tribal representatives about the different consequences this rule would have in various regions of the country. In Indian Health Service areas such as California and Alaska, the Indian service population would be drastically reduced.

California representatives have projected that as many as 50,000 Indians in that State would lose their eligibility, while in Alaska, as much as 15 percent of the current Native population would be rendered ineligible. We are extremely pleased to hear that this committee will be conducting separate hearings in these two areas to examine the unique problems involved in the eligibility question there.

In other Indian Health Service regions such as the Phoenix area and the United South and Eastern Tribes area, the rule is projected to have an opposite effect. More Indians will become eligible, especially for contract health care services, and there has been no indication that additional funds will be made available to address this additional demand.

The Indian Health Service is already faced with a staggering shortage in contract care dollars, with more than $64 million reported in deferred services for the current fiscal year. We simply cannot afford to add to this amount.

The disparities in how the Indian Health Service eligibility rule is projected to affect the Indian population illustrate how unwise it would be to permit this rule to go into effect. From the beginning of the controversy over the Indian Health Service eligibility rule, the National Indian Health Board has taken the position that before any change can be made, there must first be an area by areas impact analysis conducted in full cooperation with tribal governments. A copy of our position is attached.

Such an analysis should begin with the most basic of questions: do we need to change from the eligibility regulations that presently govern the Indian Health Service? These regulations have, after all, served us well for over 30 years.

If tribes determine there is indeed a need for change, they must be provided a full report as to how the various options will affect their people. Only then can they be expected to make an appropriate response.

The National Indian Health Board believes that the strength of S. 2382, aside from the fact that it places a three-year moratorium on any changes in Indian Health Service eligibility guidelines, is its requirement for a comprehensive study on revisions of Indian Health Service eligibility criteria to be conducted in cooperation with tribal governments. We are especially pleased that the bill calls for the study to examine not only the financial and demographic effects of such a change but to consider the health status, cultural, social and economic impacts on Indian individuals and communities as well.

The National Indian Health Board believes that S. 2382 reflects the sentiment expressed by tribal leaders and individual Indian health consumers about the Indian Health Service final rule on eligibility, and we urge this committee to give this bill its prompt consideration.

We would also ask that the committee consider the following additions to the bill, consistent with the resolution supported by tribal representatives at the "Nashville '88" meeting:

1. Include language directing the Secretary of Health and Human Services to withdraw the September 16, 1987 final rule.
2. Include language that specifically establishes the existing Indian Health Service eligibility criteria as statute.
3. Require an indefinite moratorium, rather than three years, on the implementation of any new rules and regulations until such time as Congress approve the need for such change.

This concludes my remarks. Again, I wish to thank you for the opportunity to comment on this important bill, and I will be able to respond to any questions that you may have.

Thank you very much.

[Prepared statement of Mr. Whitecrow appers in appendix.]

Senator MELCHER. Thank you, Jake.

Now, we will hear from Dr. Emery Johnson.

STATEMENT OF EMERY JOHNSON, M.D., FORMER DIRECTOR OF THE INDIAN HEALTH SERVICE

Dr. JOHNSON. Thank you, Mr. Chairman.

I am pleased to appear before you this morning in support of S. 2382. I have provided you a written statement for the record, and I would just like to summarize it in perhaps five points and a conclusion if I might.

Senator MELCHER. Your entire statement will be made part of the record. Please proceed, Doctor.

Dr. JOHNSON. I think the first point is to recognize that the original intent of establishing the Indian Health Service by the Congress was to elevate health status, to eliminate what the Congress at that time called the "appalling" status of Indian health.

As health people, given that responsibility, it was very clear at the beginning that we had to deal with access on the part of Indian people to health care and acceptance of health care. So, anything that created a barrier that would tend to keep people away from health care would not be supportive of the intent of Congress.

That is the reason that the initial regulation was drawn as broadly as it was, to eliminate barriers for Indian people. I came into the program right at the last day the Bureau of Indian Affairs had the program, so we lived under the old Bureau rules for a while which were really to try to keep people away from health care, not to bring them into health care.

So, the original regulation was really designed to open up the system and to allow people to get care, because that is what was critical if you were going to elevate health status.

The second point is that Dr. Rhoades is quite right. The Indian Health Service has been rationing medical care from day one. There is absolutely no question about that.

The difference is that, in the early days, we were rationing health care on the basis of what we called relative medical need—what did the patient need versus the health needs of someone else, emergencies versus, say, cosmetic surgery. Secondly, were there other resources available to them, for example, a Veterans' hospital or something like that.

We did this rather than trying to ration medical care as it appears they are now doing on the basis of excluding individuals. There is a difference in rationing. Both are methods of rationing medical care, but in one you are doing it on the basis of relative medical need. In the other, you are doing it on the basis of excluding individuals in total.

The third point is that, over time, of course, there has been continued pressure on the program. The Indian population has expanded rapidly. Birth rates have been relatively high. Mortality rates have decreased dramatically. So, you have a natural population increase, and there has been an increase in terms of new tribes recognized by the Congress, restored by court order, or otherwise identified through the Bureau of Indian Affairs' Federal Acknowledgement Program.

So, we have two sources of increasing numbers of Indian people who are eligible under the current regulations. When you add to that the issue that, frequently, the congressional appropriation does not even meet the inflationary costs of medical care and the accelerating cost of very high tech medical care—life-saving but very high cost—the Indian health program has been increasingly in a squeeze of demands for its resources continually beyond its ability to provide it.

Every report, including the Grace Commission report that Jake talked about, it has acknowledged the fact that there are not sufficient resources, all the way up to the Office of Technology Assessment's report a couple of years ago that again talked of rationing.

Now, the Grace Commission report I would sort of define as saying that the patient is too long for the bed. So, instead of getting a longer bed, let's just cut off the patient's legs. That is the process that has driven this interest in reconsidering eligibility.

Now, I think it is entirely appropriate to reconsider eligibility. I mean, we have had this since 1956. I spent my career under this eligibility from reservation physician up at White Earth to the director. In that many years, surely it needs to be revisited periodically.

I think also that because it is clear that the administrative agency must try to find some regulation, some rule, some mechanism to cover a gap. As the Supreme Court said in Ruiz, if Congress creates a gap, implicitly or explicitly, in a program that is created and funded by Congress the administrative agency then must make some rule to try to cover that gap.

As that gap has gotten larger and larger, the Indian Health Service has felt forced to try to come up with some sort of rule. The process they followed, through the regulation process, I believe, was probably appropriate up until the point that the Secretary issued the final rule. I think all of us expected that after the consultation and after they had reviewed the rule and come up with another rule, that they would go back to the tribes for consultation again.

If we have learned anything in 20 years, it is that you can't make decisions and then tell the tribes. You have to go back and involve them in that final decision making process.

My sense is that if the Secretary had taken that rule and, instead of publishing it, had sent it back and opened it up for consultation again, we could have worked out many of the problems that people are bringing up.

Much of what I have heard across the country in objections to the rule are clear misunderstandings, confusions, and things like that which could have been eliminated, I think, if we had had a consultation process instead of publishing the final rule. However, once that rule was published, the game was over, and the thing was doomed.

The major issue that has been raised finally is clearly this issue of membership and what that means. We talked earlier about being accepted as part of an Indian community, and we mean that in terms of part of an Indian family. As we looked at it, how do you elevate health status if you selectively eliminate one person out of a family for some kind of a technicality?

I think the most obvious was the issue of tuberculosis. If you have a family constellation and there is tuberculosis, you can't exclude any individual within that family or that community of families. We in public health look upon the community as our patient.

If you leave some of those out, you cannot possibly control that disease. You can't possibly, then, elevate health status. So, we see those as artificial barriers to carrying out the mission of the program.

The concept of defining eligibility on an individual basis in relationship to descendancy troubles me. That, to me, seems very unwise.

I thought that we put aside the issue of the Indian programs as racial programs in the Supreme Court decision in *Mancari* v. *Morton*. To start again with an individual descendancy kind of thing—I think OTA speaks to this as well in their study—again puts you on the edge of being concerned with a racial program.

At the same time, I have every concern for those groups and those Indian people whose tribes were destroyed by the Federal Government, California tribes, for example, whose treaties were not ratified and who were dispersed over broad areas. Clearly, there must be some mechanism developed but, hopefully, some mechanism that would permit them to become part of some federally recognized entity so that they could be served by the Indian Health Service on the same basis as a government to government basis rather than on some individual issue.

My conclusion, then, Senator Melcher, is that the only responsible resolution to this issue at the moment, I think, is the passage of S. 2382. Withdraw the current rule and start the consultation process over again. Let's get the facts out, have the tribes in full participation as we get clear facts, so we can then deliberate together as to what that final regulation should be so that we don't lose sight of what I think is the critical issue, and that is that the purpose here is to elevate health status, not find ways to exclude people from health care.

I will be glad to answer any questions that you might have.

[Prepared statement of Dr. Johnson appears in appendix.]

Senator MELCHER. Thank you, Emery.

First of all, Mr. Bibo, you touched on the very point, the uncertainty of who would be eligible after these regulations. I think there are two bottom lines in this, and the first one is, who would be cut off that is now eligible.

You mentioned 400 probably on Rocky Boy which, I guess, would be about 25 percent and 1,000 on Fort Belknap.

Mr. BIBO. 1,000 on Fort Belknap.

Senator MELCHER. Which would be another 25 to 35 percent. So, that——

Mr. BIBO. How they would become eligible, though, I don't know. I have no way of knowing who——

Senator MELCHER. Yes; I think the most peculiar thing about this is that the regulations really don't assure anybody that a great percentage are not eligible if they were adopted. Now, that uncertainty in an area such as Havre, serving both Rockyboy and Fort Belknap I find absolutely intolerable. That is the bottom line.

Now, if Montana were somehow an exception, that might give some merit to what IHS is attempting to do in their regulations, but we are not an exception. We are typical. We know that.

So, the first bottom line I reach is that a large number of people who are now eligible and who think they are going to be eligible next year would suddenly become ineligible.

The second bottom line I reach is exactly what you testified to. What does this mean to the hospitals that are now serving on a contract basis Indian people?

I can't tell you how disturbing this is to me, because the very delivery of health care to the entire area, both Indian and non-Indian, depends upon some stability of your hospital.

In the Special Committee on Aging, we are reviewing one of the problems with rural hospitals in terms of Medicare. Of course, to a certain degree, we get into Medicaid also, and we are finding that rural hospitals are at a disadvantage.

That means that the stability of the rural hospitals, at best, is not too good right now. We probably need to make some change in Medicare as it affects rural hospitals in order to reestablish stability of rural hospitals.

I am going to ask you, Mr. Bibo, did anybody consult you from IHS about these proposed regulations or these regulations which they feel are finalized?

Mr. Bibo. No.

Senator Melcher. No.

Mr. Bibo. Along the way from time to time, you might get a spattering of information on particular bills and what have you. We got this after the publication in September or whatever it was. We were meeting with the Indian Health Service, though, with regard to DRG's prior to—well, for a year or so.

It seems to me we are getting a double load at the same time, not knowing the effect of one, and DRG's is a complete unknown through Indian Health Service at the same time. We just signed our contract with them on April 1, so I don't really know the exact effect of that at this point in time.

However, historically, as you know, since we were investigated at one time and thought our services were so much more costly than everyone else and found out we were one of the lowest cost services within the Billings area back in the early 1980's, we have had contracts with the Indian Health Service over a long period of time prior to DRG's. So, the community and the hospital is committed to serving the Indian people in that area. It is just how many of these programs become a portion of your total people to be served before you are in trouble.

The hospitals smaller than ours are even in worse condition, obviously. You are right. In the frontier areas which are many of the areas in Montana, the rural hospital situation and the Indian health situation are linked together because of the distances between the facilities, the size of the facilities, and the payment mechanisms.

Senator Melcher. You also make the point that unless the health care is provided close to the family, you disrupt the family and that has an adverse affect. I certainly agree with that.

I think, oftentimes, if it means that health care for an individual of the family is going to be provided but at a location a great distance from where they live, what results is delayed health care and, therefore, more costly health care, jeopardizing the health status of the individual patients.

I find it difficult to understand, with all the problems we are having with health care delivery for not just Indians but other non-tribal members and non-Indians in rural areas, why we would be confronted with a regulation that has not been discussed with the people directly involved who receive the health care and also with the people who would provide the health care.

Jake, were you consulted on this regulation and in what way?

Mr. WHITECROW. The only way we were consulted was that we were notified that the Indian Health Service was considering making some changes. At that particular time, we began developing the National Indian Health Board's position on eligibility.

Senator MELCHER. Did they ask you for input?

Mr. WHITECROW. No.

Senator MELCHER. No; well, Emery, in your experience, is this the general way IHS goes about procedures and changing basic regulations?

Dr. JOHNSON. I think the regulation process is a very difficult one in the Department of Health and Human Services. It is such a huge department, and they tend to view, I think, regulations in a somewhat different way than you and I would view them in dealing with an Indian community. It is sort of an arm's length adversarial type of thing.

For example, if the Food and Drug Administration is coming up with regulations on pharmaceuticals, we are not really going to have the kind of dialog and the joint development that we normally have when we come up with Indian policy, Indian health related decisions with the tribes. That is sort of collegial kind of development.

That is not normally typical of the way the department would write regs. When you have to have a reg and then it goes into the department system, that is a very bureaucratic, very precise, lawyer driven kind of process. In my experience in the department, they never really did understand the kind of consultation that we always felt was necessary.

They always said you should just make the decisions and the tribes will follow. We kept saying no, you have to start out there and work your way on up, and you come to a consensus, not the other way around.

So, I think it is just a generic problem that the Indian Health Service has always had in the complexities of this department. That is why I think it is so important that Congress has to give explicit directions to the department when it comes to this regulation.

I could give you the story of our difficulties in the Public Law 93-638 regulations, almost a catastrophic problem in trying to get any regulations out at all. So, it has always been that way with the department, and only Congress has the ability to shape that process in the correct way, I think.

Senator MELCHER. Well, I believe, as the National Indian Health Board has clearly stated, this bill is really a minimum bill. You have recommended, Jake, or the board has recommended that we make the current regulation statutory prior to the revision which I fully understand why you make that recommendation, because you want stability.

Then, if it is going to be changed, that would require and Act of Congress to change it.

Mr. WHITECROW. Right.

Senator MELCHER. So, yes, indeed, I agree with you. I believe this bill that I have introduced is just a minimum bill. We may want to add to it to be more precise, because these regulations, I find, totally unworkable from the standpoint of individual families, from the standpoint of the tribes, Alaskan Natives, and I find it totally unworkable as far as the communities are concerned with their hospitals that have contract service.

Undoubtedly, there would be some people benefitted by the regulations. I don't ignore that. I think, Emery, your example is appropriate. When you find over the years that the patient is too long for the bed, you better not saw off the patient. You better find a longer bed. I think that is what we are faced with.

In the long run, neither Congress nor the American public is going to allow people who need health care to go wanting for health care. However, the American public and Congress can very easily find a period of time when a large number of people could go wanting for health care to the detriment of those individuals and their families and to the detriment of the health care delivery system that would be racked and torn asunder.

I know what happens if Havre Hospital is disrupted from providing the health care to the Indians. The Indian people there are going to suffer. A lot of them are going to suffer, and the hospital is going to be in a turmoil of how to scatter out the additional charges.

The baby is doing fine, by the way, Mr. Bibo. You people did a very fine job. We all appreciate it.

Mr. Bibo referred to our latest granddaughter in his testimony, and he is absolutely right. If the contract service is going to be torn apart for that hospital, a lot of Indian people are going to suffer and then the other patients are going to have to make up the difference in order to keep the hospital operating.

Did you have something, Jake?

Mr. WHITECROW. Yes, sir; I would like to just add a comment in regard to a consultation process. I think this particular issue substantiates the fact that there is no true real consultation process in effect between either the Department of Health and Human Service or the Interior Department when working with tribes.

We have developed a consultation paper. It is in draft form. It has not been completely adopted as yet, but as soon as it is adopted, I would be very happy to supply you and your committee with a copy of that particular paper. If you would like, I can give you a copy of the draft paper just as soon as I get back to my office.

Senator MELCHER. I think that is critical, and I am glad you made that point, because the procedure for consultation must be better established in this particular instance, but we need a model for consultation with the tribes and other America Natives so we know what we are doing. This absolutely does require consultation prior to any development of regulations or statute, as you recommend, because we have to know what we are doing. We can't operate in as vague a position as we are operating right now.

Thank you all very much for your testimony. It is most helpful to us.

Our final witnesses are Earl Old Person, Chairman of the Blackfeet Tribal Council; and Jonathan L. Taylor who is the Principal Chief of the Eastern Band of Cherokee Indians.

Welcome, Jonathan.

Mr. TAYLOR. Thank you.

Senator MELCHER. Earl, you are listed first, so please proceed.

STATEMENT OF EARL OLD PERSON, CHAIRMAN, BLACKFEET TRIBAL COUNCIL, BROWNING, MT

Mr. OLD PERSON. Thank you, Mr. Chairman.

I think the previous people that have talked about the ruling on eligibility have covered pretty much the things that I think we are all concerned. I just want to talk in general at this time.

First of all, my name is Earl Old Person. I am the Chairman and Chief of the Blackfeet Tribe. I am here on behalf of the Blackfeet people on the Blackfeet Reservation.

I have written testimony that I am submitting in support of the proposed legislation, S. 2382.

I want to thank you for the help that you are giving us, Senator Melcher, insofar as having the Blackfeet Hospital in place at this time and for the help that you have given in those efforts.

Just listening to the people discussing the rules and regulations or the final rule, I was just wondering about the people back on the Blackfeet Reservation that were attempting to discuss this particular legislation or the ruling. Listening to the confusion that there seems to be right here in these chambers, why expect my people to have an understanding of this particular ruling?

It has caused the Blackfeet people to discuss and to get into two groups of people discussing the eligibility of enrollment on the Blackfeet Reservation. These two groups have come to the point where they have forgotten about the issue of the final ruling. It has set a precedent for discussing who is going to be eligible to become a Blackfeet member. That was very discouraging to the people of the Blackfeet Nation.

I, for one, have been an advocate for Indian health for the Blackfeet people as well as people throughout this nation. I have always considered that health is number one in anybody's life, whether you are an Indian, non-Indian. It is very important in people's lives.

I have always said that if we do not have the kind of health that we expect, we cannot function. We cannot do too much.

We have Indian people who are away from reservations. I have said this time and again—it is not by choice, but it is a must. As you know, we as people from the Indian reservations are limited in many ways in many cases, for instance, in jobs, education.

When we first got the word of this final ruling, it was from our service unit director. When the people got the word of the final ruling, perhaps they practically panicked. They began to wonder what we can do and how we are going to deal with this.

An ad hoc committee was organized. It was directed to get together and to see how they can deal with this particular ruling. But because of this ad hoc committee that was going out and starting discussing who was going to be eligible, what are we going to do about our enrollment, another group was organized, disputing with the ad hoc committee. This is what this particular ruling has caused and is causing, in particular, on the Blackfeet Reservation.

We as the tribal leaders have tried to talk with these people and tried to ease them down, saying let's first find out what this particular ruling is all about and then let's find out what we can do about it. I am just bringing out what this has caused with my people.

So, I do believe that in this day and age, there was a time a few years ago that perhaps we did not become engaged with the many kinds of sicknesses that we have today. This is the time that our Indian health is needed the most, not to try to say who can be cared for and who cannot be cared for.

I, as the leader, went out and encouraged my people back in the late 1950's to use the facilities that we had on the reservation as far as doctors and health care facilities which they did. They certainly began using these facilities.

To know that in later years that there will be a question as to who will be able to use the facilities that we have, sometimes we begin to wonder when we have to deal with these kinds of rules and regulations pertaining to our health.

I want to thank your committee and the people who have addressed this at the national level, that you have considered the voice of the people in wanting a delay. In my testimony, I had gone a little bit further. I had said that I wanted it withdrawn in its entirety until we know or come to a point where we better understand what the rules and regulations will be in the health care for the Indian people.

However, I believe that this delay will help us as the tribal leaders, the people who are concerned, the people who are working with the Indian Health Service to get together and better understand how they are going to regulate and where we will be satisfied with whatever the outcome may be and that the people may be giving a full understanding as to what the future will be for our Indian health services.

I am very concerned about the Indian people today, especially for those who are very handicapped in the way of not understanding the kinds of things that are taking place today and, in this case, the Indian Health Service. We have a lot of our old timers today who live on the reservation who are dependent upon our Indian health care services.

These are the kinds of people that we need to get to and to have them understand what is taking place. We do not want to disrupt the enrollment for Indian people. We want them to continue understanding and have a better working relationship as to who is going to be eligible and who will become members of that particular tribe and still be able to work with our Indian Health Service people in trying to find ways in which they can best service the people.

We know that money is always the question. It is the enemy of this nation. Whenever we talk about things that we want to do or we want to gain, money comes into question.

However, I want to say that when it comes to health, I think our Government should be able to give that number one priority. If it is money, let us do what we can to help provide so that there can be services that we will not dispute over but try to encourage one another to use in a way that will better help the people as a whole.

Today, I certainly appreciate this opportunity to express my thoughts on this particular legislation on behalf of the Blackfeet people. With that, I want to thank you again for allowing me this time.

[Prepared statement of Mr. Old Person appears in appendix.]

Senator MELCHER. Thank you, Earl.

Jonathan, we will hear from you now.

STATEMENT OF JONATHAN L. TAYLOR, PRINCIPAL CHIEF OF THE EASTERN BAND OF CHEROKEE INDIANS, AND ON BEHALF OF THE UNITED SOUTH AND EASTERN TRIBES, INC., NASHVILLE, TN

Mr. TAYLOR. Mr. Chairman, my name is Jonathan L. Taylor. I am Principal Chief of the Eastern Band of Cherokee Indians. We are located in the heart of the Great Smokey Mountain National Park. We have a membership of about 10,000 members.

In the area that I am coming to talk about today, Mr. Chairman, we have 17 tribes that belong to the United South and Eastern Tribes. In that area, we have two Indian Health Service hospitals, one at Cherokee and one at Choctaw. Also, in the other tribes, we have some out-patient clinics.

Our board of directors here in Washington passed a resolution asking that the proposed regulations that were put in final form on September 16, 1987 be totally withdrawn. Also, Mr. Chairman, we are supporting your bill, S. 2382, which delays this action for 3 years for a 2-year study. I think this is what should have happened to start with.

Also in your bill, you recognized government to government action with Indian tribes and the Federal Government and State governments. Also, consultation with the Indian tribes.

I sat back here, Mr. Chairman, and listened to nearly everybody who spoke. They didn't have this consultation with IHS or any Federal office on these regulations. We heard about it in the mountains. We never did think it would ever come to pass.

However, every time we get over one stumbling block, it seems like there is another one that comes up. For a while, they had us fighting over the eligibility of one-quarter and above. I think we got that sort of put under the rug, and all this stuff comes about.

I think when Emery Johnson was the Director of the Indian Health Service, the tribes at that point, when anything like this happened, they did get consultation from the Federal Government. I don't think anything like this would have gone out in final form without the tribes being consulted about this.

I also heard Jake Whitecrow testify a while ago who is the Chairman of the National Indian Health Board. Even though the National Indian Health Board represents all Indian tribes in the health field, they didn't get this consultation. They just said these regulations are coming up.

So, what did we have to do? We had to find some way to combat what they already put on us. I think using S. 2382 and S. 30, a committee be made up of IHS personnel and also tribal leaders throughout the country to come up with some regulations that both the Federal Government and the Indian people can live with.

Also, I heard Dr. Rhoades say there was a possibility that 125,000 other people would become eligible. Right now, Mr. Chairman, we don't have the contract care money about halfway through the year right now. Nobody has told us if that many more people become eligible where the money is coming from.

I know that Congress is passing good bills for Indian people. I think Public Law 437 that was passed by Congress, I think, back in Emery Johnson's day, was for Indian education in health fields. Through that process, Mr. Chairman, our tribes has now got an M.D. that graduated this past summer from the University of North Carolina using that method to go to school. We also graduated a veterinarian using the same method that the Indian Health Service and the Congress passed for Indian people to use.

I think this is what IHS should be doing, Mr. Chairman, letting Indian people know first what is going to happen and let them be a part of what is happening. We are not here to fight with IHS or Congress or the Senate. All we are asking, Mr. Chairman, is a chance to be brought in and consulted with when things like this are going to happen.

We have to answer to our people on the reservations. We don't know what is happening until it is already put in place.

These are just some of the things I wanted to say. I do have written testimony that has been presented to your committee, Mr. Chairman, and I would like that to be made a part of the record.

Again, I would like to thank this committee and especially the Senator for the wisdom of putting this bill together that will at least give the tribes 3 years with a 2-year study to come back to the Congress with some recommendations, Mr. Chairman, that both the Indian people and the Government can live with.

With that, I will be available to answer any questions that the chairman or other committee members would like to ask. Again, thank you for letting me come up and share some of my concerns.

[Prepared statement of Mr. Taylor appears in appendix.]

Senator MELCHER. Jonathan, your entire statement will be made part of the record as well as your comments.

I want to commend both of you, Earl and Jonathan, for very vividly describing what the concerns are of Indian tribes and the dangers that are lurking in these regulations. We will pursue for their consideration of this bill on this committee as rapidly as possible. There will be some hearings both in Alaska and in California, and that is good, because we will start the dialogue from the Indian people themselves directly to the committee in a public hearing process which adds some further ammunition for what we need to do here.

We are going to have to take action in Congress. This is not something that we can rely upon the Indian Health Service to determine. It is too critical a matter, and it is one that individual tribes must address and must consult with us on, and we will go on from there.

As earlier stated, I think the bill is a minimum. We may have to add to the bill to be more definitive in it, but at least we have the framework in which to let Indian tribes discuss with us just what is needed here.

I thank you both very much again for your excellent testimony.

Mr. OLD PERSON. Thank you.

Mr. TAYLOR. Thank you, Mr. Chairman.

Senator MELCHER. The committee record will be held open for 2 weeks from this date, and we will receive written testimony from anybody who cares to submit it.

The committee is adjourned.

[Whereupon, at 11:58 a.m., the committee adjourned, to reconvene subject to the call of the Chair.]

APPENDIX

Additional Material Submitted for the Record

STATEMENT OF SENATOR JOHN MELCHER

ON

S. 2382, A BILL TO DELAY THE IMPLEMENTATION OF A PROPOSED IHS ELIGIBILITY RULE

MR. CHAIRMAN, THE HEARING THAT WE ARE HAVING TODAY ON S. 2382 IS VERY IMPORTANT FOR THE HEALTH CARE OF INDIANS AND ALASKAN NATIVES. THE SUBJECT BEFORE US IS ELIGIBILITY FOR IHS SERVICES -- A FUNDAMENTAL ISSUE WHICH TOUCHES THE LIVES OF EVERY INDIAN AND ALASKAN NATIVE FAMILY.

CONGRESS HAS FOUND THAT THE HEALTH CARE STATUS OF THE AMERICAN INDIAN IS THE LOWEST IN THE COUNTRY. IN ORDER TO TURN THAT AROUND, CONGRESS HAS SET THE GOAL OF RAISING THE HEALTH STATUS OF THE INDIAN PEOPLE TO THE HIGHEST POSSIBLE DEGREE. SOME PROGRESS HAS BEEN MADE ON REACHING THAT GOAL, BUT WE STILL HAVE A LONG WAY TO GO. I AM AFRAID THAT THE PROPOSED IHS REGULATIONS WOULD BE A SUBSTANTIAL SET-BACK ON THE PROGRESS WHICH HAS BEEN

MADE SO FAR AND MAKE IT VERY DIFFICULT TO REACH THE GOAL WE HAVE SET.

HEALTH CARE FROM IHS SHOULD BE MADE AS ACCESSIBLE AS POSSIBLE TO INDIAN PEOPLE. IHS SHOULD BE ENCOURAGING MORE USE OF IHS SERVICES -- PARTICULARLY IN THE AREAS OF PREVENTIVE MEDICINE. THE REGULATIONS WHICH WE WILL CONSIDER TODAY WOULD HAVE THE REVERSE EFFECT -- THEY WOULD CREATE ADDITIONAL BARRIERS TO HEALTH CARE FOR MANY INDIAN PEOPLE. I DO NOT THINK CONGRESS SHOULD APPROVE ADMINISTRATIVE ACTIONS WHICH WOULD HAVE THIS EFFECT.

S. 2382 IS A BILL I INTRODUCED A FEW WEEKS AGO TO PREVENT IHS FROM IMPLEMENTING A REGULATION WHICH WOULD CHANGE THE CRITERIA UNDER WHICH INDIANS ARE ELIGIBLE TO RECEIVE HEALTH CARE FROM THE INDIAN HEALTH SERVICE. THIS BILL IS NECESSARY BECAUSE THE REGULATIONS WHICH IHS HAS DEVELOPED WOULD CUT OFF MANY INDIANS FROM IHS CARE WHICH IS THE ONLY SOURCE OF MEDICAL CARE FOR MANY PEOPLE ON RESERVATIONS.

THE IHS REGULATIONS ARE VERY POORLY THOUGHT OUT. IHS HAS NOT CONDUCTED STUDIES AND CANNOT SAY WITH ANY CERTAINTY WHAT THE SOCIAL AND FINANCIAL IMPACTS OF THE CHANGE WOULD BE. HEALTH CARE IS TOO IMPORTANT TO THE INDIAN PEOPLE TO ALLOW A CHANGE THIS

BASIC TO OCCUR UNLESS WE KNOW PRECISELY WHAT THE IMPACTS WOULD BE.

UNDER THE IHS RULE THREE CHANGES WOULD BE MADE: NON-TRIBAL MEMBERS WOULD BE CUT OFF FROM CARE. "CONTRACT HEALTH" CARE SERVICES WOULD BE EXTENDED TO ALL MEMBERS OF FEDERALLY RECOGNIZED TRIBES LIVING OFF THE RESERVATION IN HEALTH CARE SERVICE AREAS. FINALLY, PEOPLE WOULD HAVE TO FORMALLY APPLY FOR SERVICES.

TRIBES AND ALASKAN NATIVE VILLAGES ARE VIGOROUSLY OPPOSED TO THE REGULATIONS. THEY HAVE ASKED FOR A MORATORIUM AND A STUDY WHICH WILL PROVIDE MORE INFORMATION. S. 2382 WOULD ACCOMPLISH THAT OBJECTIVE AND ALSO REQUIRE IHS TO ACTIVELY CONSULT WITH THE INDIAN PEOPLE ABOUT ANY CHANGES IN ELIGIBILITY WHICH ARE PROPOSED.

I BELIEVE THAT HEALTH CARE FOR INDIAN PEOPLE IS A TRUST RESPONSIBILITY AND CONGRESS MUST GUARD AGAINST ANY CHANGES WHICH WOULD DAMAGE THIS IMPORTANT TRUST.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT OF

EVERETT R. RHOADES, M.D.

DIRECTOR

INDIAN HEALTH SERVICE

BEFORE THE

SELECT COMMITTEE ON INDIAN AFFAIRS

U.S. SENATE

JUNE 21, 1988

Mr. Chairman and Members of the Committee:

I am Dr. Everett Rhoades, Director of the Indian Health Service (IHS). I am pleased to be here today to discuss our efforts to revise the eligibility criteria covering most of the IHS program and the proposal contained in S.2382 which would delay implementation of these new regulations. I would like to begin with a brief discussion of the background which led up to the publication of the new eligibility regulations on September 16, 1987 (attachment 1).

The basic authority for IHS to provide services to Indians is the Snyder Act of 1921. The Act authorizes the expenditure of funds "for relief of distress and conservation of health" of "Indians throughout the United States". The Snyder Act does not define eligibility requirements or the details of any program. That has been left to Departmental regulations and later acts of Congress.

Congress has generally provided funds for services to federally recognized Indians on or near reservations. The Federal Government's underlying policy is to serve Indians, not as individuals, but as members of Federally recognized governmental entities. The regulations currently governing eligibility for services from IHS require an individual to be "of Indian descent belonging to the Indian Community served by the local facilities and program". The regulations have been construed liberally to include anyone who can reasonably be regarded as an Indian regardless of degree of Indian ancestry or tribal affiliation. These regulations were published in 1956.

IHS interpreted the regulations to authorize it to provide service to any otherwise eligible Indian who presented himself or herself to an IHS facility. Contract care, however, presented a problem in that it was not clear who was on or near a reservation. The growing importance of contract care increased the seriousness of the problem. Each IHS Area had its own policy which lead to a suit and a court order for IHS to establish a uniform definition of what constituted "on or near a reservation". The result was the 1978 publication of regulations governing eligibility for contract health services including a definition of "on or near". In addition to meeting the older criteria, an individual would now also have to meet a defined residency requirement, i.e., "on or near", as well as demonstrate a close economic and social tie with the local tribe in order to be eligible for contract health services.

This was the only change affecting Indian eligibility for basic IHS services in the 32 year existence of the current eligibility regulations. Aside from this change, however, and notwithstanding the fact that the original regulation had well served both IHS and the Indian community for many years, there was increased dissatisfaction expressed with the regulation. There was a growing concern that IHS resources were being directed beyond what was thought to be the intended scope of the program. When health services were provided on the reservation or in areas primarily inhabited by closely knit Indian populations it was readily apparent who belonged to the community to be served. With shifts in population away from the reservations, increasing inter-marriage, greater urbanization of traditionally rural areas (with a resulting increase in the Indian/non-Indian mix of the population), and the expansion of services to new areas through contract health care, individuals belonging to the Indian community were no longer as readily identifiable as in former times.

These problems were made worse by the rapid increase in the cost of medical care, the continued improvement in both the quality and accessibility of IHS services, the increased acceptance by the Indian community of the IHS program and the growing Indian population all of which combined to dramatically increase the demands placed upon the IHS system. Simply put, the question became how many "real" Indians is IHS serving and do the current regulations still provide effective and understandable criteria, both for the Indian people and those who administer the program? A corollary to this question is, are the criteria consistent with Congressional intent as expressed in legislation? If not, then Congressional intent is what needs to be clarified.

Alternatives were suggested by the Grace Commission and the 1983 Director's Task Force on Contract Health Services. The Grace Commission criticized IHS regarding its methods of determining Indian eligibility. The Commission recommended that IHS define its service population as members of Federally recognized Indian tribes with at least 1/4 degree of Indian blood.

The Director's Task Force on Contract Health Services recommended that IHS eligibility be limited to persons of Indian blood who: are members of Federally recognized tribes; live within a clearly defined service area; and formally apply for IHS services.

Congress itself had recognized the problem when it directed that:

> IHS must address the issue of an expanding service population in terms of defining who is or should be eligible for IHS services . . . (H.R. Rep. No. 97-942, 97th Cong. 2nd Sess. at pg. 108, 1982).

As a result of the above, the Department initiated a process leading to the publication of new eligibility regulations on September 16, 1987.

Since there has been concern expressed in many quarters that this was done without consultation with the tribes and the Indian people, I would like to briefly outline the process that was followed before turning to a discussion of the new regulations themselves.

On June 6, 1983, two Federal Register notices (48 FR 25273) were published which solicited comments on a number of options for eligibility criteria and verification (attactment 2). Copies of these notices were sent to each tribe and interested Indian organization.

A total of 242 responses were received. These consisted of 28 from tribal governments, 4 from tribal organizations, 15 from other Indian organizations, 4 from other organizations, and 191 from individuals. Of the 191 comments from individuals, 186 were form letters from Minnesota stating that IHS should retain its current eligibility requirements. In general, the 51 tribes and other organizations responding supported use of a blood quantum requirement for IHS eligibility. They were concerned, however, that changes must be made carefully to avoid hurting a large number of Indians where unemployment is a problem and no health insurance exists. The majority of the tribes responding stated that if a blood quantum criteria must be imposed, 1/4 Indian blood should be the criteria employed.

On June 10, 1986 the Department published a notice proposing changes in the IHS eligibility regulations (attachment 3). Again, a copy of the notice was sent to each Federally recognized tribe and interested Indian organization. The comment period was originally 120 days. This was extended to 150 days following requests from a number of Alaska Native organizations which were having difficulty meeting the schedule because of the fishing season (attachment 4).

During the comment period, IHS sponsored over 120 public meetings, some with translators and all locally scheduled and advertised, resulting in over 10,000 pages of transcripts. Copies of these transcripts were provided to this Committee. In addition, we received over 11,000 submissions from 16,000 commentors ranging from individuals to 172 tribes. All issues and suggestions raised were considered. The final rule represents a careful consideration and balancing of all views.

Though it may be true that many tribes and Indian people do not agree with the final regulations, it is not true that they were not consulted and their views seriously considered. The new regulation was the result of a process that took over four years.

We are all aware that there is a great deal of opposition being expressed by the Indian community against implementation of the new regulation. This was made very clear to me by the Indian attendees at a recent tribal consultation meeting sponsored by the IHS at Nashville. As promised, I have forwarded their concerns and views to the Assistant Secretary of Health. But many of the fears expressed were based on misunderstanding of the regulation such as the belief that IHS was requiring tribes to have an enrollment system. We are currently developing training materials for IHS and tribal personnel who will implement and administer the regulations. We plan to utilize these materials to orient our service population in order to correct these misunderstandings.

I would like to turn now to the regulation itself and briefly describe what it provides. In some case I will go into more detail to try to correct some misunderstandings which I believe are widely held.

The major issue raised during the comment period concerned the proposal to have a 1/4 blood quantum test which was opposed by the overwhelming number of those who commented. Of the more than 16,000 commentors who opposed the blood quantum criteria, including Members and Committees of Congress, a majority did so at least partially on the basis that tribal membership should be a sufficient criteria. Interestingly enough, at least 125 tribes have blood quantum of at least 1/4 degree as a membership requirement.

In response to the comments, the blood quantum requirement was dropped from the final regulation and the requirement for tribal membership retained. The only exception to tribal membership is for minor children who are not themselves eligible for membership but who are natural children of tribal members. Eligibility for tribal membership is not sufficient. There is to be a uniform residency requirement for both direct and contract health. The resulting health service delivery areas (HSDA) can be adjusted administratively rather than requiring legislation or a change in regulations as is currently the case with contract health service delivery areas (CHSDA). Former residents of HSDAs may go to any HSDA for direct (not contract) services. Appeal procedures are provided for denials of either direct or contract services. The close economic and social ties test is abolished. Beneficiary Indentification Cards are to be issued. The rule is uniform nationwide.

I would like to address the major issues as I understand them. With regard to tribal membership, three major issues have surfaced. Two deal with evidence needed to document tribal membership. First, a number of tribes have expressed concern that they do not have enrollment systems. The Bureau of Indian Affairs (BIA) has expressed similar concern. The regulations do not require an enrollment system. Though an enrollment system would be acceptable, the regulation is very broad stating that membership can be demonstrated "as prescribed by the charter, articles of incorporation, or other legal instruments or traditional processes of the tribe" (42 CFR 36.16(b)(1)).

Any method by which a tribe identifies its members is acceptable. This approach is consistent with self-determination, tribal sovereignty, and the government to government relationship since the tribes will determine and verify who their members are.

Second, concern has been expressed with the method of determining tribal membership, i.e. certification by the BIA (42 CFR 36.16 (b)(2)). The intent here was not to put the BIA into the position of determining tribal membership. Indeed, this would have gone against the entire concept of this regulation in emphasizing tribal control. The purpose was to permit the BIA to act where it was authorized or required to so act by legislation, court order, tribal agreement etc. I have had a recent meeting with Assistant Secretary for Indian Affairs Swimmer to clarify this issue and have agreed to pursue the issuance of an interpretive rule or notice with the Office of General Counsel.

BIA is generally involved, however, in issuing Certificates of Degree of Indian Blood (CDIB). Though these do not always prove tribal membership they do establish Indian descent which is essential for tribal membership.

Third, we have become aware that a number of tribes are considering expanding their membership requirements. In some cases this membership will be solely for health service purposes and will be accomplished by establishing different categories of membership. Though this is apparently within the applicable laws, we are concerned with the long term consequences of such actions. In addition to eventually unfairly distorting the allocation of IHS resources, we are concerned with the long terms effect on such tribes.

The concern has been expressed both that the purpose of the rule was to reduce the number of eligible Indians and that the rule will increase the demand for services. Those concerns are both partly correct. While it is true that the rule tightens elibility requirements based on tribal membership and combines rules for direct and contract services, it was not intended simply to reduce the number of eligible Indians. Its purpose is also to enable IHS to better allocate resources, enhance coordination of patient care in IHS and non-IHS facilities, and administer the program.

On the other hand, under the new rules it is expected that the number of people eligible for contract health services (CHS) will increase. This is because the new rule does away with the "close economic and social ties" test previously required for off-reservation Indians. The IHS has estimated that approximately 125,000 Indians will become eligible for CHS under the new rules, excluding the impact of the tribal membership requirement. These are people who are already counted as part of the IHS service population. They simply will now be eligible for a service from which they were previously excluded because they did not have the needed close economic and social ties with the tribe within whose CHSDA they live.

However, only experience will show how many Indians will actually take advantage of their new CHS eligibility. This points out a problem with any study of the impact of a proposed eligibility criteria. Only experience will show how many of the those theoretically eligible will take advantage of their eligibility. For example, though the current IHS eligible service population in California is estimated to be approximately 79,000, the IHS registration system shows a population of approximately 49,000 and a user population of about 40,000.

But the forgoing discussion of numbers obscures the real issue. The IHS is charged with the mission of raising the health status of Indians to the highest possible level. Without definitive program eligibility criteria there is ultimately no way to either effectively direct resources to the target population, to accurately identify their needs and health status, or to measure the IHS impact on their health status. The goal of the Indian Health Care Improvement Act will be made immeasurably more difficult without conforming eligibility requirements.

The growing demand for IHS services, as evidenced by an expanding service population, will out-strip the supply of medical services that can be provided by any amount of IHS resources that can rationally be contemplated. This has greatly exacerbated the pressure on IHS to find ways to ration contract health services to the Indian population in ways that meet the often conflicting demands for more health care, equity in the distribution of resources, and the mission to raise the health status of Indians to the highest possible level. As a result we are frequently in the unsatisfactory and ultimately untenable position of providing contract health services only in emergency and life threatening cases.

The above does not mean that we have not made estimates of the overall impact of the new regulation. The IHS does not have extensive data on tribal membership. The IHS patient registration system will be updated with tribal membership information as part of the implementation process for the new eligibility regulations. However, by using current IHS patient registration data, BIA tribal enrollment data and data from the 1980 Census Supplementary Questionnaire for American Indians, we have estimated that 100,000 to 150,000 people who now utilize IHS services are not members of a federally recognized tribe. We anticipate that many of the people who are not currently members of a federally recognized tribe will become members in order to retain their eligibility. The impact will vary by IHS Area, but this can only be determined once experience is gained with the new rules in terms of the net change in actual users and utilization. It should be noted that similar difficulties would exist for any proposed eligibility criteria.

It is true that we do not have enough data to make reasonable impact estimates on an Area by Area or Service Unit by Service Unit basis. An earlier attempt to obtain base data on membership, blood quantum, and residency was halted when the cost of obtaining such information rose above what was available. An early test of the study was met with some resistance to providing data from a number of tribes. IHS does not have easy access to all the sources of data that would be required to make site by site estimates.

Costs of such an effort would depend upon the detail and reliability desired. For example, we have estimated that the detailed study of California Indians required by the proposed amendments to the Indian Health Care Improvement Act, P.L. 94-437, would cost over $600,000. We do not believe such detail is warranted in this case, therefore the cost from the California estimate should not be extrapolated to the entire nation. Nevertheless, we are talking about a considerable effort that would be costly. I would suggest that, if a study is considered necessary, a statistical approach would be more appropriate and timely and that it should be done by the Congressional Office of Technology Assessment or some similar body experienced in such impact assessments.

Another major concern is how to deal with those who will lose eligibility. We do not plan to "...jerk the rug out from under them." A great deal of thought has gone into providing a sensitive and humane transition. Much of the approach reflected in the regulation was first developed by IHS in the transition that followed enactment of the statute that restricted the eligibility of non-Indian spouses to a few specified situations.

Originally, the regulation was scheduled to take effect six months after publication, followed by a six-month grace period during which those who would lose eligibility under the new rule and who had utilized IHS or IHS funded facilities within three years prior to the publication date would continue their eligibility. Language in the Fiscal Year 1988

Appropriations Act, P.L. 100-102, further delayed implementation until September 16, 1988.

The regulations provide a number of transition provisions which would mitigate its impact on anyone no longer eligible under the new rules. These provisions include the grace period, provision for minor Indian children, and provisions to assure continuity of care for persons under active treatment or with chronic degenerative conditions on the day they lose eligibility for up to an additional year beyond the grace period. Further, the regulation provides appeal rights to those losing eligibility and requires that those patients be offered assistance in locating other health care providers and medical assistance programs.

Thus, those with the means to obtain insurance would have ample time to do so. Those without means would have ample time and IHS assistance in applying for other medical assistance programs. Emergency services would continue to be available on the same basis as it is to non-beneficiaries today. Those under treatment would not be abandoned. Special provisions would apply to minor Indian children and those with chronic degenerative conditions. An appeals process would be available to all.

In the same spirit of concern for those who are not getting needed services, however, I would be remiss if I did not also point out that anecdotal information indicates that there are many tribal members, often reservation residents with a high degree of Indian blood, who are being squeezed out of services in IHS facilities by people with very tenuous, if any, tie to an Indian tribe or their Indian ancestry.

I would like to return to the issue of tribal membership as an eligibility requirement. We believe tribal self-determination calls for such an approach. In addition, Congress has in recent years defined "Indian" in several related statutes essentially to mean a person who is a member of a federally recognized tribe. The Indian Self-Determination and Education Assistance Act (P.L. 93-638), a dominant statute guiding the federal government's present relationship with Indian tribes, defines an Indian as "a member of an Indian tribe" (25 USC 450b (a)). The Indian Health Care Improvement Act has a definition similar to P.L. 93-638 relative to federally recognized Indians (25 USC 1603 (c)) and both have the same definition of an "Indian Tribe."

The Cmnibus Drug Bill, P.L. 99-570 ("Subtitle C - Indians and Alaska Native") contains a provision restricting the target population for the Indian Health Service portion of the Act to ". . . members of Indian tribes" (section 4226(4)). The term "Indian tribe" is defined exactly as that term is defined in P.L. 93-638 to mean federally recognized tribes (section 4204(3)).

Moreover, statutes restoring or recognizing the Federal trust relationship and Federal services to Indian tribes consistently provide for restoration of federal services and benefits to ". . . members of the tribe . . . ." The most recent example of this is the August 18, 1987, Ysleta Del Sur Pueblo and Alabama and Conshatta Indian Tribes of Texas Restoration Act, P.L. 100-89. In those few instances where Congress has wanted broader eligibility it has very specifically spelled out its intent, e.g., the urban Indian, manpower, and alcoholism programs in P.L. 94-437.

In light of this evidence of Congressional intent, we are somewhat surprised by Congressional and Indian expressions in favor of a further delay in the implementation of a rule which fully meets the expressed requirements of the Congress and which acknowledges that it is the tribes themselves that should determine who their members are and, therefore, who is eligible for IHS services.

It should also be pointed out that proposals in both Houses of Congress to amend the Indian Health Improvement Act contain directives to identify unmet health needs of Indians and to direct resources to these needs. "Indians" is defined in both the House and the Senate bills as members of federally recognized tribe except for those special programs mentioned above. It would make a nullity of much current and proposed legislation to have inconsistent eligibility criteria, to say nothing of the impossibility of meeting those previously mentioned tests of equity, access, and improvement of Indian health status.

The Constitutional and statutory basis for the IHS program is not race but the government-to-government relationship between the Federal government and the Indian tribes.

We understand that history has sometimes resulted in what can most charitably be described as a confused tribal status. But these situations are political not medical problems and are beyond the ability of the IHS to correct.

In addressing the specific situation in California, the preamble to the final regulation contains a statement that is applicable elsewhere.

> We believe the most reasonable and prudent poilcy (sic) with respect to eligibility for services from the IHS is to make it clear that such services are available to members of Federally recognized tribes. It is within the jurisdiction of the BIA Federal acknowledgement program and the Congress to correct any historical anomalies with respect to Indian groups not now recognized.

The same analysis applies to determining individual Indian status.

This Committee is actively engaged in addressing these very difficult problems. Today's hearing is only one of a series and I commend the Committee for its efforts.

I am sympathetic to the Committee's concern with the lack of definitive data on the impact of the eligibility rule. I experienced the same concern and frustration. But eventually I had to take the position that the IHS must follow the lead of Congress and define who "should be eligible" for services and mitigate any adverse impact of that decision with what I hope are fair and humane transition procedures. For me to have approached it otherwise would, I fear, have resulted in nothing being done.

S.2382, a bill to delay the implementation of a certain rule affecting the provision of health services by the Indian Health Service, calls for a three year moratorium on implementation, and a two year detailed study of the local impact of the regulation with consultation with tribal governments and urban Indian health care programs.

Consultation with urban Indian organizations is not appropriate in this case. Urban programs are funded by IHS under Title V of P.L. 94-437. Eligibility for these programs is covered by a separate statutory definition of Indian which is not affected by the new regulation. The urban Indian program eligibility definition is considerably broader than that contained in the regulation. Consultation with the tribes and the individual Indians affected (including those living in urban areas) is, however, appropriate.

The need for modification of eligibility requirements is as urgent now as when the process was initiated. Setting limits on the eligible service population will enable us to focus the available IHS resources so that services can be better directed at health needs in a manner that will maximize the effect of our resources on the Indian community. To retain the current eligibility rules would leave unaddressed the growing perception that IHS resources are being directed beyond the intended scope of the program and will not provide IHS with the tools necessary to better plan and focus its resources. The new regulations simplify, clarify, and tighten eligibility requirements without being overly restrictive and without creating major disruptions in service delivery patterns.

To a limited extent Congress is considering the question of who should be eligible for no charge services from the IHS in the pending bills to amend the Indian Health Care Improvement Act (i.e. S.129 and H.R. 2290). We believe this is a more appropriate mechanism than a moratorium and study as proposed in S.2382.

That ends my prepared statement. I will be happy to attempt to answer any questions you may have.

ATTACHMENT - 1

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Public Health Service

42 CFR Part 36

Indian Health Service

AGENCY: Health Resources and Services Administration, Public Health Service, HHS.

ACTION: Final rule.

SUMMARY: These are final rules governing who may receive health services from the Indian Health Service (IHS). Under these rules, and eligible person must be: (1) A member of a federally recognized Indian tribe, and (2) reside within a designated Health Service Delivery Area (HSDA). The regulation provides for a one-year transition period prior to implementation and a waiver for Indian children (18 and under) who are ineligible under the new rule and who have at least one natural parent who is eligible. These eligibility requirements are applicable to both direct and contract health services.

Under section 103(a) of the Indian Self-Determination Act, Pub. L. 93–638, 25 U.S.C. 450g(a), IHS funds may be expended only for carrying out the "functions, authorities, and responsibilities" which the Secretary would otherwise have carried out with those funds. Therefore, tribes and tribal organizations operating facilities under Pub. L. 93–638 must also adhere to the eligiblility provisions and procedures in these rules and are not authorized to serve persons with IHS funds who do not meet these criteria.

DATES: Effective March 16, 1988, except for the *Transition Provisions,* Subpart D, §§ 36.31 through 36.34, which are effective September 16, 1987 through September 18, 1989.

FOR FURTHER INFORMATION CONTACT: Richard J. McCloskey, Indian Health Service, Room 6A–20, 5600 Fishers Lane, Rockville, Maryland 20857, Telephone: 301–443–1116. (This is not a toll free number).

SUPPLEMENTARY INFORMATION: On June 10, 1986, a notice of proposed rulemaking (NPRM) was published in the **Federal Register** (51 FR 21118 et seq.) proposing changes to the regulations governing who may receive health services from the IHS. Interested persons were given until October 8, 1986, to submit written comments, suggestions, or objections. Because of the interest expressed in this proposal, on October 10, 1986 a notice was published in the **Federal Register** (51 FR 36412) extending the comment period to November 7, 1986.

A. Changes Made From the Proposed Rules

These rules are the product of a careful analysis of over 11,000 submissions by individuals; groups; Indian and non-Indian organizations; state, local, and tribal governments; and the Congress submitted to the Department during the comment period. In addition, we received approximately 10,000 pages of transcripts taken at more than 120 public meetings held at selected locations throughout the country. On the basis of this analysis the Department has modified the proposed rules as noted below:

1. The proposed eligibility requirement that persons must be one quarter (¼) or more Indian or Alaska Native ancestry has been deleted.

Many commentors expressed concern that inclusion of a specific blood quantum requirement would interfere with a tribe's sovereignty by eliminating some tribal members from eligibility based upon racial identity rather than on the political relationship which exists between tribes and the Federal Government. Other commentors opposed the blood quantum criteria for a variety of other reasons; e.g., establishment of a blood quantum requirement would: violate Indian treaty or statutory rights; shift the Federal government's financial burden and responsibility to others; be "termination"; be racial discrimination between Indians; divide Indian families; and present tremendous difficulties involved in proving degree of Indian descent.

The Department does not believe that any of these arguments necessarily preclude use of a specific blood quantum as a criteria for receipt of Federal health benefits. As we indicated in the preamble to the NPRM, blood quantum requirements, as well as tribal membership, have historically been used by Congress, Federal agencies, and the courts to determine who is an "Indian" for purposes of Federal benefits, claims, awards, and Federal jurisdiction. Nevertheless, there is substantial merit in many of the comments submitted and the overwhelming response by Indian people, tribal governments, and the Congress, was in opposition to the blood quantum criteria. There was strong feeling in the Indian community that criteria governing eligibility for IHS services should, to the extent possible, conform with tribal membership requirements and the use of blood quantum would eliminate some tribal members from eligibility for IHS services. We agree and, therefore, have deleted blood quantum as a criteria for eligibility in the final rule.

In addition, we have deleted the definition of Indian ancestry which specified descent from a member of a Federally recognized tribe. This was proposed as a means of calculating Indian blood quantum. Since the blood quantum criteria has been dropped and the tribal membership requirement remains, the definition is no longer needed.

2. Section 36.12 has been revised to delete the language in (a)(1) "* * *, or eligible for membership in, * * *" This language was originally included to permit those people of Indian descent who are eligible for, but not currently enrolled in, a federally recognized tribe to be eligible for IHS services. Although some commentors were against limiting eligibility to members of tribes, a majority of commentors, in opposing the blood quantum criteria, did so partially on the basis that tribal membership should be sufficient criteria. We have decided that any person eligible for tribal membership but not enrolled will have more than enough time to become a member during the one year transition period provided for in this regulation. This decision is consistent with our decision that only members of Federally recognized tribes will be eligible for IHS services.

Those Indian people who are eligible for tribal membership but who do not wish to exercise their membership eligibility for whatever personal reasons they may have, are free to make this choice. We recognize that they will also be choosing to be ineligible for IHS services. This same result follows when a tribal member chooses to move beyond the geographical range of the IHS program. In both cases, however, the individual has it within their power to change their selection.

3. The NPRM proposed to make non-Tribal Indians eligible if they were at least one-half (½) or more Indian descent. We have deleted this criteria because of our decision that eligibility should be based on tribal membership rather than blood quantum and because of the overwhelming opposition expressed to any blood quantum requirements. In opposing blood quantum, a majority of commentors did so at least partially on the basis that tribal membership should be a sufficient criteria. We agree. Services are provided to Indian people because of the political relationship which exists between tribes and the Federal Government rather than on a racial basis.

4. We have included an exception to the tribal membership requirement for minor children (18 and under) of tribal members. The child must have one natural parent who is a tribal member and the child must meet all other requirements. This exception does not apply to non-Indian adopted, foster or step-children of eligible Indians.

This exception is in response to commentor concern that minor Indian children of tribal members also be eligible for IHS services even if the children are not themselves tribal members. To some extent, family divisions have already occurred with the statutory curtailment of services to non-Indians enacted in 1983. (Pub. L. 97–394). Non-Indian foster, adopted, and step-children would continue to be excluded under this rule. Nevertheless, we believe it to be good public health policy to limit such family divisions as much as possible. In our view, an exception to the tribal membership requirement for Indian children not eligible for tribal membership is a reasonable accommodation which will help mitigate any harsh impact of this rule.

5. Section 36.12 as proposed would have allowed former residents of HSDA's and their minor children to return only to their home communities to obtain services without reestablishing residency. The final rule will permit former residents of HSDA's and their minor children to return to *any* HSDA (not necessarily their former community of residence) to obtain services available in IHS and IHS funded facilities. They will not, however, be eligible for contract health services. To preclude Indians from obtaining IHS services could restrict their mobility and discourage them from seeking employment in off reservation areas.

6. Section 36.15(d), governing changes in HSDA boundaries, has been revised to make it clear that while any tribe may request a change in HSDA boundaries, consultation with *all* the affected tribes is required. This is to assure that no tribe is unknowingly impacted by expansion or contraction of the HSDA resulting from the request of another tribe.

7. Section 36.12(b)(4) has been revised to delete language that would have required the prior written approval of the Service Unit Director, for good cause shown, to permit continued eligibility for a 90-day grace period after an eligible person ceased to reside in a HSDA. Language similar to that contained in the present regulations has been substituted, permitting persons who cease to reside in a HSDA and who are neither students nor transients to be eligible for services for a period of 90 days from such departure. This 90 day grace period is included in order to provide a reasonable period for the making of alternative arrangements for health services. We do not wish to impose an additional administrative burden by requiring either prior written approval of the Service Unit Director or the need to establish good cause.

8. Language has been added to provide for a transition period prior to implementation of the new rules. Many commentors expressed concern that those excluded by any new rules should be allowed adequate time to arrange alternate coverage for their health care needs. In order to provide time to obtain alternate services and to complete treatment underway we have provided for a transition period of one year as follows:

The rule will not take effect until six months after publication to permit time for administrative steps necessary for implementation and education. After implementation there will be a second six month grace period during which those who would lose their eligibility under the new regulation and who had made use of an IHS or IHS funded facility within 3 years prior to the implementation date, shall retain eligibility if they reside in a HSDA.

Provisions have been included to assure that persons no longer eligible under these rules but who on the last day of the one year transition period are under treatment for any active condition or under treatment for a chronic degenerative disease or condition will continue to be considered as IHS beneficiaries until such time as their condition may be stabilized and other health care providers and medical assistance programs can be located. These provisions provide that:

(1) Inpatients in IHS and IHS funded facilities and those receiving inpatient care under contract, including contract health services, may continue to receive services at IHS expense until the need for hospitalization and follow-up services has ended as determined by the responsible IHS or tribal physician, all other conditions being met including medical priorities;

(2) Those actively undergoing a course of outpatient treatment either in IHS and IHS funded facilities or through contract health services, termination of which would impair the health of the individual patient, may continue to receive the treatment at IHS expense for a reasonable length of time, until the course of treatment reaches a point where it may safely be terminated or the patient transferred to other providers as determined by the responsible IHS or tribal physician. In addition, treatment for chronic degenerative conditions may be provided for no longer than 1 year beyond the point where it was otherwise safe to transfer treatment to other providers; and

(3) All patients receiving care under (1) and (2) above shall be notified that, after discharge from care provided under any of the above circumstances, they will no longer be eligible for service as IHS beneficiaries. These patients shall be offered assistance in locating other health care providers and medical assistance programs.

9. For purposes of clarification, language has been added to the definitions of "appropriate ordering officials" and "Service unit Director" to include the equivalent contract official administering IHS programs under such authority as the Indian Self-Determination Act, Pub. L. 93–638.

10. The definition of "Program Director" has been deleted as this term is no longer used by the IHS.

11. The first sentence in § 36.12(c), has been revised to clarify that the provision applies both to IHS facilities and programs and to facilities and programs operated and/or owned by tribes and funded by the IHS.

12. Language has been added to § 36.15 (a) and (b) to clarify that HSDA's may only include geographic areas within the United States. Under the Snyder Act, appropriations are authorized for "Indians throughout the United States". This will remove from eligibility Indians residing outside the United States who in the past may have received direct services from IHS facilities.

13. Language has been added to § 36.16 to clarify that IHS will only maintain currently eligible people in its registration system and further that persons requesting Beneficiary Identification Cards (discussed later) need not submit new evidence of tribal membership and residence if such evidence is a already on file. The IHS will make the determination as to whether or not the materials on file are sufficent.

B. Discussion of comments

1. A number of commentors (approximately one-third) suggested that we retain the current eligibility rules rather than adopt the proposed changes. There was widespread confusion, however, as to what the current requirements were with a significant number under the mistaken opinion that the tribes currently determine eligibility for IHS services.

rule but is also prudent policy and consistent with Congressional intent.

9. This rule does away with the "close economic and social ties" test. If an Indian person resides in a HSDA and is a member of a Federally recognized tribe, he or she is eligible for IHS services both direct and contract. There were 37 tribal comments and 317 individual comments in favor of a residency requirement. Those in favor of residency did not address the close ties test. Nevertheless, we believe that deleting the close ties test is consistent with the overall approach and will simplify administration of the program and provide the individual with a clearer eligibility requirement.

10. Several commentors requested that implementation of the proposed regulations be postponed for various periods because there had not been enough consultation with the tribes. The issues involved in the NPRM were first presented in June 6, 1983, when a **Federal Register** notice (48 FR 25273) was published which outlined a number of options for eligibility criteria for Indians served by the IHS and solicited comments on these options. The proposed regulations have received extensive public exposure with a 150 day comment period resulting in over 11,000 submissions by individuals; groups; Indian and non-Indian organizations; state, local and tribal governments; and the Congress. In addition, over 120 public meetings were held to take public comments which resulted in over 10,000 pages of transcripts.

11. Some commentors were in favor of giving the tribes power to clear, veto, or even solely define the geographic composition of the HSDA's. This could defeat the concept of residency on or near reservations. As we indicated in the proposal, it is our intention to leave current service delivery areas in place at the outset to avoid any disruptions in service delivery patterns. The rule permits any Indian tribe located within a HSDA to submit to the appropriate Area Director(s) requests for changes in HSDA boundaries based on criteria contained in the regulation. The rule includes consultation with any other tribes affected by the proposal. The tribal request, all tribal comments, and the Area Director's recommendation and findings will be submitted to the IHS Director or the Director's designee, who makes the final determination.

12. A number of commentors were concerned that the rule might have a disproportionate impact on Indians in California and, therefore, special rules should be included for California Indians to take into account special historical factors in that State, such as failure to ratify treaties and past termination policies. Other commentors expressed opposite concerns claiming a special definition of California Indians would expand the current Indian service population in California and in effect "protect" the current California service population from the effects of any new eligibility rules, thus being unfair to Indians in other parts of the country who would be subject to and would have to bear the impact of any new rules.

Establishing separate eligibility requirements for California could set a precedent both for local diverse eligibility criteria and for inclusion of non-tribal Indian groups in other states. We have concluded that, absent specific Congressional direction to do so, it would be inappropriate for the Department to treat California Indians differently under this rule. The relationship between the Federal government and Indian Tribes is well established. Mechanisms are in place to correct historical anomalies through the BIA Federal acknowledgement program. We believe the most reasonable and prudent poilcy with respect to eligibility for services from the IHS is to make it clear that such services are available to members of Federally recognized tribes. It is within the jurisdiction of the BIA Federal acknowledgment program and the Congress to correct any historical anomalies with respect to Indian groups not now recognized.

C. Fee for Service Care

As was explained in the proposed rule we are also updating the regulation to specify those circumstances in which the IHS may provide direct services at its facilities on a fee-for-service basis. These include:

(a) In emergencies under section 322(b) of the Public Health Service Act, 42 U.S.C. 249(b), and 42 CFR 32.111 of the regulations;

(b) To Public Health Service and other federal beneficiaries under Economy Act (31 U.S.C. 1535) arrangements to the extent that providing services does not interfere with or restrict the provision of services to Indian and Alaska Native beneficiaries; and

(c) To non-beneficiaries residing within the HSDA under policies approved by the tribe or tribes located on the reservation but only to the extent that providing services does not, as determined by the IHS interfere with or restrict the provision of services to Indian and Alaska Native beneficiaries.

This rule will not necessarily eliminate the actual provision of services to those individuals who will no longer retain eligibility. They may still receive services from IHS facilities on a fee-for-service basis under one of the above conditions.

D. Beneficiary Identification Cards (BIC)

Only 92 comments were received on this subject and of these 84 were opposed to the use of BICs. Nevertheless, a registration process and issuance of BICs will enable the IHS to have more accurate knowledge of beneficiary populations and make it easier to identify beneficiaries and to expedite the provision of services in the various clinical settings. The absence of a card will not preclude an otherwise eligible Indian from obtaining services, though it may delay the administrative determination that an individual is eligible for services on a no charge basis.

E. Evidence of Tribal Membership

We have added a provision to clarify responsibilities for determining or demonstrating that a person is a member of a federally recognized tribe. Identification of federally recognized tribes is a BIA responsibility and the IHS relies on the BIA both for identification of federally recognized tribes and for resolution of controversies as to whom or what body officially speaks for or represents a tribe. Obtaining acknowledgment as a Federally recognized tribe is governed by regulations at 25 CFR Part 83. The IHS will work with both the BIA and the tribes to determine membership but it is the responsibility of the individuals to demonstrate that they are member of a federally recognized tribe.

Under this rule, the IHS will recognize two methods of demonstrating tribal membership:

(1) Documentation that the applicant meets the requirements of tribal membership as prescribed by the charter, articles of incorporation, other legal instrument or traditional process of the tribe and has been officially designated a tribal member by an authorized tribal official or body; or

(2) Certification of tribal enrollment or membership by the Secretary of the Interior acting through the (BIA).

This will help local IHS officials identify beneficiaries as well as provide necessary guidance to resolve any disputes regarding tribal membership.

F. Comments Beyond Scope

Several comments were received that went beyond the scope of the notice. They include suggestions: (1) That IHS charge Indians for services provided, or require a means test; and (2) that IHS use contract health service funds to buy group health insurance policies.

Determination Concerning Impact of the Rule

This rule does not have cost implications for the economy of $100 million or more independent of the IHS appropriation, nor will it result in a major increase in cost for consumers, industries, or Government agencies, nor will it adversely affect competition. Therefore, the Secretary has determined that the rule is not a "major rule under Executive Order 12291, and a regulatory impact analysis is not required. Further, these regulations will not have a significant economic impact on a substantial number of small entities, and therefore do not require a regulatory flexibility analysis under the Regulatory Flexibility Act of 1980.

Paperwork Reduction Act

Sections 36.12(b)(2), 36.14(a), 36.15(d), and 36.16 contain information collections that are subject to approval by the Office of Management and Budget under the Paperwork Reduction Act of 1980, which have been approved under control number 0915–0107.

List of Subjects in 42 CFR Part 36

Alaska natives, Indians, Health, Health facilities, Health service delivery areas, Contract health services.

Dated: May 28, 1987.

Robert E. Windom

Assistant Secretary for Health.

Approved: July 8, 1987.

Otis R. Bowen,

Secretary.

For the reasons set out in the preamble, we are amending 42 CFR Part 36 as follows:

PART 36—[AMENDED]

1. The authority citation for Part 36 continues to read as follows:

Authority: Sec. 3, 68 Stat. 674; 42 U.S.C. 2003, 42 Stat. 208, sec. 1, 68 Stat. 674; 25 U.S.C. 13, 42 U.S.C. 2001 unless otherwise noted.

2. Subpart A is amended by revising the title, removing § 36.1, and redesignating §§ 36.2 and 36.3 as §§ 36.1 and 36.2 respectively, to read as follows:

Subpart A—Purpose

Sec.

§ 36.1 Purpose of the regulations.

* * * * *

§ 36.2 Administrative instructions.

* * * * *

3. Subparts B and C are amended by:

A. Redesignating § 36.12(c) as § 36.11(d);

B. Revising § 36.12;

C. Revising and redesignating § 36.21 as § 36.10;

D. Redesignating § 36.24 as § 36.13;

E. Removing § 36.14 and by revising paragraph (a) introductory text of § 36.25 and then by redesignating § 36.25 as § 36.14. The revised paragraph (a) introductory text would read as set forth below;

F. Adding new § 36.15 and § 36.16 to read as set forth below; and

G. Adding OMB control number 0915–0107 at the end of §§ 36.12, 36.14, 36.15, and 36.16.

The revised and added portions of Subpart B read as follows:

§ 36.10 Definitions.

As used in this subpart: "Alternate resources" means resources other than those of the Indian Health Service available and accessible to the individual, such as health care providers and institutions, health care payment sources, or other health care programs for the provision of health services (e.g., Medicare, Medicaid, State or local health care programs or private insurance), for which the individual may be eligible or would be eligible except for the individual's eligibility for any IHS program.

"Appropriate ordering official" means, unless otherwise specified by contract with the health care facility or provider or by a contract with a tribe or tribal organization, the ordering official for the Service Unit in which the individual requesting contract health services or on whose behalf the services are requested, resides.

"Area Director" means the Director of an Indian Health Service Area Office designated for purposes for administration of Indian Health Service Programs.

"Contract health services" means health services provided at the expense of the Indian Health Service from public or private medical or hospital facilities other than those of the Service or those funded by the Service.

"Emergency" means any medical condition for which immediate medical attention is necessary to prevent the death or serious impairment of the health of an individual.

"Health Service Delivery Area" means a geographic area designated pursuant to § 36.15 of this Subpart.

"Indian tribe" means any Indian tribe, band, nation, or other organized group or community, including any Alaska Native village or regional or village corporation as defined in or established pursuant to the Alaska Native Claims Settlement Act, 43 U.S.C. 1601 *et. seq.*, which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.

"Reservation" means any Federally recognized Indian tribe's reservation, Pueblo, or colony, including former reservations in Oklahoma, Alaska Native regions established pursuant to the Alaska Native Claims Settlement Act (43 U.S.C. 1601 *et seq.*), and Indian allotments if considered reservation land by the Bureau of Indian Affairs.

"Reside" means living in a locality with the intent to make it a fixed and a permanent home. The following persons will be deemed residents of the Health Service Delivery Area:

(1) Students who are temporarily absent from the Health Service Delivery Area during full time attendance at programs of vocational, technical, or academic education including normal school breaks;

(2) Persons who are temporarily absent from the Health Service Delivery Area for purposes of travel or employment (such as seasonal or migratory workers);

(3) Indian children placed in foster care outside the Health Service Delivery Area by order of a court of competent jurisdiction and who were residents within the Health Service Delivery Area at the time of the court order.

"Secretary" means the Secretary of Health and Human Services and any other officer or employee of the Department of Health and Human Services to whom the authority involved has been delegated.

"Service" means the Indian Health Service.

"Service Unit Director" means the Director of Indian Health Service programs for a designated geographical or tribal area of responsibility or the equivalent official of a contractor administering an IHS program.

§ 36.12 Persons to whom health services will be provided.

(a) Subject to the requirements of this subpart, the Indian Health Service will provide direct services at its facilities, and contract health services, as medically indicated, and to the extent that funds and resources allocated to the particular Health Service Delivery Area permit, to persons of Indian or Alaska Native descent who:

(1) Are members of a federally recognized Indian tribe; and

(2) reside within a Health Service Delivery Area designated under § 36.15; or

(3) Are not members of a Federally recognized Indian tribe but are the natural minor children (18 years old or under) of a member of a Federally

BEST AVAILABLE COPY

recognized tribe and reside within a Health Service Delivery Area designated under § 36.15.

(b) Subject to the requirements of this subpart, the Indian Health Service will also provide direct services at its facilities and, except where otherwise provided, contract health services, as medically indicated and to the extent that funds and resources allocated to the particular Health Service Delivery Area permit, to people in the circumstances listed below:

(1) To persons who meet the eligibility criteria in paragraph (a) of this section except for the residency requirement, who formerly resided within a Health Service Delivery area designated under § 36.15, and who present themselves to any Indian Health Service or Indian Health Service funded facility (and to minor children of such persons if the children meet the eligibility criteria in paragraph (a) of this section except for the residency requirement). Contract health services may not be authorized for these individuals;

(2) To a non-Indian woman pregnant with an eligible Indian's child but only during the period of her pregnancy through post-partum (generally about 6 weeks after delivery). In cases where the woman is not married to the eligible Indian under applicable state or tribal law, paternity must be acknowledged in writing by the Indian or determined by order of a court of competent jurisdiction;

(3) To non-Indian members of an eligible Indian's household if the medical officer in charge determines that the health services are necessary to control acute infectious disease or a public health hazard; and

(4) To an otherwise eligible person for up to 90 days after the person ceases to reside in a Health Service Delivery Area when the Service Unit Director has been notified of the move.

(c) Contract health services will not be authorized when and to the extent that Indian Health Service or Indian Health Service funded facilities are available and accessible to provide the needed care. When funds are insufficient to provide the volume of contract health services needed by the service population, the Indian Health Service shall determine service priorities on the basis of medical need. Contract health services will not be authorized when, and to the extent that, alternate resources for payment:

(1) Are available and accessible to the beneficiary, or

(2) Would be available and accessible if the beneficiary were to apply for them, or

(3) Would be available and accessible under state or local law or regulation in the absence of the individual's eligibility for contract health services from the Indian Health Service or Indian Health Service funded programs.

(d) The Indian Health Service may provide direct services at its facilities on a fee-for-service basis to persons who are not beneficiaries under paragraphs (a) and (b) of this section under a number of authorities including the following:

(1) In emergencies under section 322(b) of the Public Health Service Act, 42 U.S.C. 249(b), and 42 CFR 32.111 of the regulations;

(2) To Public Health Service and other Federal beneficiaries under Economy Act (31 U.S.C. 1535) arrangements to the extent that providing services does not interfere with or restrict the provision of services to Indian and Alaska Native beneficiaries; and

(3) To non-beneficiaries residing within the Health Service Delivery Area when approved by the tribe or tribes located on the reservation but only to the extent that providing services does not interfere with or restrict the provision of services to Indian and Alaska Native beneficiaries.

(Approved by the Office of Management and Budget under control number 0915–0107)

§ 36.14 Reconsideration and appeals.

(a) Any person who has applied for and been denied health services or eligibility by the Indian Health Service or by any contractor contracting to administer an Indian Health Service program or portion of a program, including tribes and tribal organizations contracting under the Indian Self-Determination Act, shall be notified of the denial in writing together with a statement of all the reasons for the denial. The notice shall advise the applicant that within 30 days from the receipt of the notice the applicant * * *

* * * * *

(Approved by the Office of Management and Budget under control number 0915–0107)

§ 36.15 Health Service Delivery Areas.

(a) The Indian Health Service will designate and publish as a notice in the Federal Register specific geographic areas within the United States including Federal Indian reservations and areas surrounding those reservations as Health Service Delivery Areas.

(b) The Indian Health Service may, after consultation with all the Indian tribes affected, redesignate the boundaries of any Health Service Delivery Area followed by publication of a notice in the Federal Register. Any redesignation of a Health Service Delivery area will include the reservation, and those areas close to the reservation boundaries which can reasonably be considered part of the reservation service area based on consideration of the following factors:

(1) The number of persons residing in the off-reservation area who would be eligible under § 36.12(a) (1) and (3).

(2) The number of persons residing in the off-reservation area who have traditionally received health services from the Indian Health Service and whose eligibility for services would be affected;

(3) The geographic proximity of the off-reservation area to the reservation; and

(4) Whether the Indians residing in the off-reservation area can be expected to need and to use health services provided by the Indian Health Service given the alternate resources (health facilities and payment sources) available and accessible to them.

(c) Notwithstanding paragraphs (a) and (b) of this section, the Indian Health Service may designate States, subdivisions of States such as counties or towns, or other identifiable geographic areas such as census divisions or zip code areas, as Health Service Delivery Areas where reservations are nonexistent, or so small and scattered and the eligible Indian population so widely dispersed that it is inappropriate to use reservations as the basis for defining the Health Service Delivery Area.

(d) Any Indian tribal government may request a change in the boundaries of the Health Service Delivery Area. Such a request should be supported by documentation related to the factors for consideration set out in paragraph (b) of this section and shall include documentation of any consultation with or notification of other affected or nearby tribes. The request shall be submitted to the appropriate Area Director(s) who shall afford all Indian tribes affected the opportunity to express their views orally and in writing. The Area Director(s) shall then submit the request, including all comments, together with the Area's recommendation and independent findings or verification of the factors set out in paragraph (b) of this section, to the Indian Health Service Director or to the Director's designee for the Indian Health Service decision. The decision of the Indian Health Service Director or the Director's designee shall constitute final agency action on the tribe's request. Changes in the boundaries of Health Service Delivery Areas will be published in the Federal Register.

BEST AVAILABLE COPY

(Approved by the Office of Management Budget under control number 0915–0107)

§ 36.16 Beneficiary identification Cards and verification of tribal membership.

(a) The Indian Health Service will issue Beneficiary Identification Cards as evidence of beneficiary status to persons who are currently eligible for services under § 36.12(a). Persons requesting Beneficiary Identification Cards must submit or have on file evidence satisfactory to the Indian Health Service of tribal membership and residence within a Health Service Delivery Area. The absence of a Beneficiary Identification Card will not preclude an otherwise eligible Indian from obtaining services through it may delay the administrative determination that an individual is eligible for services on a no charge basis.

(b) For establishing eligiblity or obtaining a Beneficiary Identification Card, applicants must demonstrate that they are members of a Federally recognized tribe. Membership in a Federally recognized tribe is to be determined by the individual tribe or the Bureau of Indian Affairs. Therefore, the Indian Health Service will recognize two methods of demonstrating tribal membership:

(1) Documentation that the applicant meets the requirements of tribal membership as prescribed by the charter, articles of incorporation, or other legal instruments or traditional processes of the tribe and has been officially designated a tribal member by an authorized tribal official or body; or

(2) Certification of tribal enrollment or membership by the Secretary of the Interior acting through the Bureau of Indian Affairs.

(c) Demonstrating membership in a Federally recognized tribe is the responsibility of the applicant. However, the Indian Health Service may consult with the appropriate tribe or the Bureau of Indian Affairs on outstanding questions regarding an applicant's tribal membership if the Indian Health Service has some documentation that it believes may be helpful to the tribe or the Bureau of Indian Affairs in making their determination.

(Approved by the Office of Management and Budget under control number 0915–0107)

Subpart C [Removed and Reserved]

G. The remaining portions of Subpart C, §§ 36.22 and 36.23 are removed, and Subpart C is removed and reserved.

H. A temporary Subpart D, consisting of §§ 36.31 through 36.34 is added, effective September 16, 1987 through September 16, 1989, subsequent to which Subpart D shall be removed and reserved.

Subpart D—Transition Provisions

§ 36.31 Transition period.

(a) The transition period for full implementation of the new eligibility regulations consists of three parts:

(1) A six month delayed implementation;

(2) A six month grace period; and

(3) A health care continuity period determined by medical factors.

§ 36.32 Delayed implementation.

(a) The eligibility requirements in Subparts A and B of this part become effective March 16, 1988.

(b) During the six month delayed implementation period the former eligibility regulations will apply.

§ 36.33 Grace period.

(a) Upon the effective date referred to in § 36.32(a), individuals who would lose their eligibility under the new eligilibity regulations published on September 16, 1987, and who have made use of an Indian Health Service of Indian Health Service funded service within three years prior to September 16, 1987 (date of publication of the new eligibility regulations) shall retain their eligibility for a six month grace period ending September 16, 1988. During this grace period such individual's eligibility will continue to be determined under the former regulations except that the new residency requirements established by Subparts A and B must be met for the individual to be eligible.

(b) All individuals who receive services during the grace period based on paragraph (a) of this section and whose eligibility will terminate on September 16, 1988, shall be notified in writing that after September 16, 1988 they will no longer the eligible for services as Indian Health Service beneficiaries. Such written notice should include an explanation of their appeal rights as provided in § 36.14 of the part. These patients shall be offered assistance in locating other health care providers and medical assistance programs.

§ 36.34 Care and treatment of people losing eligibility.

(a) Individuals who lose their eligibility on September 16, 1988, (end of the grace period) and on that date are actively undergoing treatment may still be provided services for a limited period in the following circumstances:

(1) Inpatients in IHS and IHS funded facilities and those receiving inpatient care under contract, including contract health services, may continue to receive such care and necessary follow-up services at Indian Health Service expense until the need for hospitalization and follow-up services has ended as determined by the responsible Indian Health Service or tribal physician, all other conditions being met including medical priorities;

(2) Those actively undergoing a course of outpatient treatment either in Indian Health Service and Indian Health Service funded facilities or through contract health services, termination of which would impair the health of the individual patient, may continue to receive the treatment at Indian Health Service expense for a reasonable length of time, until the course of treatment reaches a point where it may safely be terminated or the patient transferred to other providers as determined by the responsible Indian Health Service or tribal physician, all other conditions being met including medical priorities.

(3) Those under treatment for chronic degenerative conditions may be provided additional treatment at Indian Health Service expense for no longer than 1 year beyond the end of the grace period notwithstanding any determination that it was otherwise safe to transfer treatment to other providers, all other conditions being met including medical priorities.

(b) All patients receiving care under paragraph (a) of this section shall be notified in writing that, after discharge from care provided under any of the above circumstances, they will no longer be eligible for services as Indian Health Service beneficiaries. Such notice shall include an explanation of their appeal rights as provided in § 36.14 of this part. These patients shall be offered assistance in locating other health care providers and medical assistance programs.

[FR Doc. 87–21106 Filed 9–15–87; 8:45 am]

BILLING CODE 4160-16-M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Resources and Services Administration

Options for Eligibility Criteria for Beneficiaries Served by the Indian Health Service

AGENCY: Health Resources and Services Administration, HHS.

ACTION: Options for Eligibility Criteria for Beneficiaries Served by the Indian Health Service (IHS).

SUMMARY: The notice sets forth a discussion of major approaches under consideration by the Health Resources and Services Administration (HRSA) for potentially revising current eligibility criteria for IHS beneficiaries to strengthen the capability of the IHS to manage existing resources.

DATE: Comments should be submitted by July 21, 1983.

ADDRESS: Send comments to: Mr. Rich McCloskey, Director, Office of Legislation and Regulations Services, Indian Health Service, Health Resources and Services Administration, Room 6A-14, Parklawn Building, 5600 Fishers Lane, Rockville, Maryland 20857.

FOR FURTHER INFORMATION CONTACT: Mr. Rich McCloskey, Director, Office of Legislation and Regulations Services, HRSA, 301/443-1116.

SUPPLEMENTARY INFORMATION: The Indian Health Service (IHS) provides a range of health care services to Indians and Alaska Natives directly or through contracts with tribes and private health organizations. In 1982, the IHS service population consisted of approximately

BEST AVAILABLE COPY

900.000 persons (64% of the total Indian population in the United States). Direct care services are available to persons who are of Indian descent and who are members of the Indian community served by the local facilities and programs. Contract care services are provided to Indians who are eligible for direct care. live in a designated geographic area adjacent to a reservation and either belong to or maintain close ties with the tribe living on the nearby reservation.

The various special programs established by the Congress to provide health services to the Indian people are based on the constitutional supremacy of the Congress to regulate commerce with the Indian tribes and are a direct outgrowth of treaties and the resulting Federal trust relationship. The IHS program is not an entitlement program. although it is generally viewed by the Indian community as an obligation of the Federal Government.

As citizens of the United States and of the States in which they reside. Indians are eligible for Federal. State. and local programs on the same basis as other citizens regardless of their membership in a federally recognized tribe or eligibility for a program based on their status as an Indian.

The IHS and HRSA are presently engaged in a review of potential approaches for strenghening the management and allocation of IHS resources to most effectively serve program beneficiaries. The objective is to maximize the use of existing and potential resources for addressing the needs of the IHS program population. The matter of eligibility criteria for IHS program beneficiaries represents a major element among the considerations under review.

The basic authority for IHS to provide services to Indians is the Snyder Act of 1921 which authorizes the expenditure of funds "for relief of distress and conservation of health" of "Indians throughout the United States." The Snyder Act does not define Indians. The IHS regulations. however. restrict services to certain categories within the overall class of eligible Indians.

The current IHS regulations for basic Indian eligibility (42 CFR 36.12(a)) were published in 1956 and read in relevant part: "Services will be made available. as medically indicated. to persons of Indian descent belonging to the Indian community served by the local facilities and program. . . ." Separate regulations were developed for Contract Health Services (42 CFR 36.22) which require applicants who do not reside on a reservation to meet addditional eligibility requirements including residing within a contract health service delivery area.

These requirements may or may not be the most effective approaches to managing the delivery of health care services to Indians. Therefore. the present management review addresses the matters of both basic program eligibility and residency within a service area.

I. Basic Program Eligibility—Alternatives

The current IHS regulations for basic Indian eligibility (42 CFR 36.12(a)) now limit services to certain categories within the overall class of eligible Indians. Generally. Congress has restricted appropriations under the Snyder Act to Indians on or near a reservation. However, being eligible as an Indian under the Snyder Act is not the same as an eligible Indian meeting the participation requirements of a program established under the authority of the Synder Act. For example. a full-blooded member of a federally recognized tribe living in an eastern city does not mean the person meets residency requirements for a particular program.

Tribal membership. on the other hand. is currently only one of a number of indices which can be used to determine if an individual is considered an Indian by the Indian community in which he lives. It is the belonging to an Indian community served by IHS that now defines who among Snyder Act Indians may receive services.

At this time. HRSA is considering various options regarding the matter of basic program eligibility. These include:

- Continue current practice. Under this option. eligibility for IHS services would continue to be based on the current regulations. Direct care services would be available to persons who are of Indian descent and who are members of the Indian community served by the local facilities and program. Contract care would be provided to Indians who are eligible for direct care. live in a designated geographic area adjacent to a reservation and either belong to or maintain close ties with the tribe living on the nearby reservation.
- Permit tribal governments to establish their own criteria for health services eligibility. This option would allow tribes to set their own requirements for determining who should receive federally-funded health services. To insure that tribes would receive a fair and equitable share of available health resources. this option might require separate critera for the allocation of IHS funds as opposed to the receipt of services. A resource allocation method would be needed to distribute IHS resources equitably among tribal populations; tribes could then establish their own criteria for determining who would be eligible for health care paid for with these resources.
- Require only membership in a federally recognized tribe. This would. in effect. adopt the definition of the term "Indian" as used by Congress in Pub. L. 93–638. the Indian Self-Determination Act.
- Require only a minimum blood quantum. Eligibility requiring a specified minimum blood quantum could be based on either the degree of Indian blood or the degree of tribal blood. For implementation purposes. the Bureau of Indian Affairs should be able to provide the necessary determination of an individual's blood quantum.

HRSA is soliciting comments on whether the major options enumerated above represent a complete and appropriate set of alternatives for consideration. HRSA would be interested in the identification of any additional options. including a combination of those already presented. for potential examination.

HRSA is also soliciting comments on a general set of issues that pertain to all of the above options under consideration. Public comment would be most beneficial if directed to each issue set forth below for each of the options being reviewed:

- For each option. are there specific constitutional or other broad legal or philosophical questions that must be considered? To what extent is the thrust of each alternative consistent or inconsistent with Federal legislation?
- For each option. what are the respective implications for Indian self determination. the role and authority of tribal governments. inter-tribal relationships. and existing Federal-Indian relationships and understandings? If negative consequences are envisioned. what steps could be taken to minimize or avoid such an outcome?
- To what extent do these alternative criteria meet or not meet the different historical. legal. and economic circumstances of individual Indian tribes and Alaska Native villages? How might the IHS beneficiary population differ among the respective options? To the extent that major inequities in access to IHS services are envisioned. what parallel actions or policies could be instituted to lessen or avoid such an impact?
- How would the options differ regarding uniformity, objectivity. and

BEST AVAILABLE COPY

accuracy of final eligibility criteria for services provided by the IHS? What actions should be considered to address any problem areas identified?

- What operational and administrative factors need to be identified that might affect the implementation of each option? What are the implications for administering there respective options resulting from such developments as the greater mobility and mixing of the Indian and non-Indian population and the greater numbers of people claiming Indian descent? What steps might be undertaken to address any problems or constraints identified?
- How would the options vary in their impact upon the complexity, fairness, and effectiveness of the resource allocation procees used by the IHS? Are there critical uncertainties affecting the full implementation of these alternatives? What actions could be considered to address any problems or uncertainties identified?

II. Service Area Residency as a Condition of Eligibility— Alternatives

As mentioned earlier, the Congress has generally appropriated funds to IHS for Snyder Act programs for Indians on or near a reservation. This is reflected in the basic eligibility regulation (42 CFR 36.12(a)) by inclusion of the phrase "served by the local facilities and program." Most IHS facilities and programs are on or near a reservation. It should be noted that in the case of direct services, the IHS policy and practice has been to serve eligible (Snyder Act) Indians who present themselves at IHS facilities to the extent IHS capabilities permit. Notwithstanding the history of appropriations and the existence of the above quoted phrase, the IHS has not established a residency requirement for direct services.

This is not the case with contract health services. As a result of the court decision in *Morton* v. *Ruiz* 94 S.Ct. 1055 et seq., and *Lewis* v. *Weinberger*, 415 F. Supp. 652 et. seq., Contract Health Services regulations were developed which require applicants who do not reside on a funded reservation to meet additional eligibility requirements, including residing within a contract health service delivery area (CHSDA).

Except where specifically spelled out in the regulation (42 CFR 36.22), CHSDAs are established by application of a formula which is termed the county option. The county option delineates the areas which will be considered "on or near" a reservation in terms of the geographic boundaries of any county which includes all or part of a reservation or which has a common boundary with the reservation. The result is the CHSDA.

The county option was not intended to be an irrevocable decision. In fact, it was explained in the preable to the NPRM for the contract care regulations that the county option definition of "on or near the reservation" may be inconsistent with the cultural traditions and social structures of some tribes and their perception of the geographic limits of their Indian communities.

The current IHS regulations, therefore, provide that, after consultation with the appropriate Indian governing bodies and taking into consideration the criteria specified in 42 CFR 36.22, CHSDA's may be redesignated by the Secretary on the basis of concepts other than the county option. Any such redesignation requires the regulation to be amended.

At this time, HRSA is considering various options regarding the matter of service area residency as a condition of eligibility. These include:

- Retain the current system which requires residency only for contract health services. Under this option the IHS would continue to have a residency requirement for contract health services but not for direct care.
- Establish a unified residency service area requirement that applies to both direct and contract health services. This approach would eliminate existing differences in the requirements for direct and contract health services.
- Retain the CHSCA system and establish different service area residency requirement for direct care. This option would institute a policy that "Snyder Act Indians" must reside in the Indian community served by the IHS facility or program.
- Abolish any residency requirement.

HRSA is soliciting comments here as well on whether the options enumerated above represent a complete and appropriate set of alternatives for consideration. HRSA would also be interested in the identification of any additional options for potential examination.

HRSA is also soliciting comments on issues that pertain to all of the above options under consideration. Public comment would be most beneficial if directed to each issue set forth below, as well as to those issues identified earlier for basic program eligibility options that are believed equally germane for the matter of service area residency as a condition of eligibility.

- What are the merits and shortcomings of adopting a unified residency service area requirement for both direct and contract health services?
- To what extent might these options affect the development and implementation of a registration system for IHS program beneficiaries? (A General Notice regarding "Options for Eligibility Verification for IHS Program Beneficiaries" is published in this same issue of the Federal Register).
- What are the respective implications of these options for urban and other Indians who may travel to IHS facilities for services? If negative consequences are envisioned, what policies could be taken to minimize or avoid such an outcome?
- How might the options affect the responsibilities of those IHS facilities that currently serve a larger number of Indians that do not reside on or near a reservation and with which they have close social and economic ties?
- What specific politicial, legal, organizational, and economic constraints may be important for each option? What steps could be undertaken to address each of the constraints identified?

It is anticipated that this General Notice will result in detailed comments regarding the options and issues set forth above. In this regard, the Administrator of the Health Resources and Services Administration is especially interested in receiving general and specific comments from American Indian and Alaska Native people and organizations representing them.

Robert Graham,
Administrator, Assistant Surgeon General.
May 29, 1983.

[FR Doc. 83-15003 Filed 6-3-83; 8:45 am]
BILLING CODE 4160-16-M

Options for Eligibility Verification for IHS Program Beneficiaries

AGENCY: Health Resources and Services Administration, HHS.

ACTION: Options for eligibility verification for IHS program beneficiaries.

SUMMARY: The notice sets forth a discussion of major factors under consideration by HRSA for verifying eligibility for IHS program beneficiaries to strengthen the capability of the IHS to manage existing resources and to implement the proposed Administration's Fiscal Year 1984 budget for the IHS.

DATES: Comments should be submitted by July 21, 1983.

ADDRESSES: Send comments to: Mr. Rich McCloskey, Director, Office of Legislation and Regulations Services, Indian Health Service, Health Resources and Services Administration, Room 6A-

14, Parklawn Building, 5600 Fishers Lane, Rockville, Maryland 20857.

FOR FURTHER INFORMATION CONTACT: Mr. Rich McCloskey, Director, Office of Legislation and Regulations Services, HRSA, 301/443–1116.

SUPPLEMENTARY INFORMATION: The Indian Health Service (IHS) provides a range of health care services to Indians and Alaska Natives directly or through contracts with tribes and private health organizations. In 1982, the IHS service population consisted of approximately 900,000 persons (64% of the total Indian population in the United States). Direct care services are available to persons who are of Indian descent and who are members of the Indian community served by the local facilities and program. Contract care services are provided to Indians who are eligible for direct care, live in a designated geographic area adjacent to a reservation and either belong to or maintain close ties with the tribe living on the nearby reservation.

The IHS and HRSA are presently engaged in a review of potential approaches for strengthening the management and allocation of IHS resources to most effectively serve program beneficiaries. The intent here is to maximize the use of existing and potential resources for addressing the needs of the IHS program population. This review takes on added importance and urgency given the context of a need to determine how best the President's Fiscal Year 1984 budget submission for the IHS can be implemented. The matter of verifying the eligibility of IHS program beneficiaries represents a major element among the considerations currently under review.

According to the present practice of IHS, an individual applying for services has a medical record established. The medical record contains the information upon which the individual's eligibility was based. Relevant to the issue under consideration, however, the individual does not receive any document attesting to his eligibility, and the method of subsequent verification of eligibility is to check the individual's medical record.

As part of a general management review of the IHS program that includes attention to the matter of eligibility verification, a proposal is being considered to change current practice and institute an IHS registration system of those eligible program beneficiaries who wish to receive services from the IHS. This option would require each IHS beneficiary (current and future) to establish that he or she has met IHS requirements for service.

The review to date has considered a variety of pros and cons regarding the adoption of a registration system versus a continuation of present practice. maintaining the current approach, for example, would clearly be less costly and, at least initially, less disruptive to present operations and service. It is believed that the adoption of a registration system, in contrast, would clearly simplify the current system of verifying eligibilty and allow the IHS to strengthen its capabilities in managing and allocating resources for meeting beneficiary needs.

While the reason for considering an IHS registration system arises from management needs, the HRSA and IHS are acutely aware of a broad set of ethical issues regarding this matter. The concept of a government-sponsored registration system for any identified population group and the specific connection of this concept to existing Federal-Indian relationships are but illustrative of the complex philosophical issues implicit in potentially altering the procedures for eligibility verification.

Preliminary discussions regarding this option have also identified the need to require the inclusion of an appeals system since benefits would be dependent upon a determination that the individual met IHS requirements. Furthermore, these discussions have identified the need to determine an individual identifier for program eligibles that are registered through this system.

In view of the breadth and significance of these considerations under review, the Health Resources and Services Administration is soliciting comments on the matters set forth above. The Administration of the Health Resources and Services Administration is specifically interested in receiving comments from American Indian and Alaska Native people and organizations representing them.

Robert Graham,

Administrator, Assistant Surgeon General.

May 29, 1983.

[FR Doc. 83-15094 Filed 6-3-83; 8:45 am]

BILLING CODE 4160-16-M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Public Health Service

42 CFR Part 36

Indian Health Services; Eligibility

AGENCY: Public health Service. HHS.

ACTION: Notice of proposed rulemaking.

SUMMARY: We are proposing changes to the regulations governing who may receive health services from the Indian Health Service (IHS). Under this proposal. an eligible person must be: (1) A member of. or eligible for membership in. a Federally recognized Indian tribe. (2) of one-quarter (¼) or more Indian or Alaska Native ancestry. and (3) reside within a designated health service delivery area. If the person is not a member of. or eligible for membership in. a Federally recognized Indian tribe. then the person must be of one-half (½) or more Indian or Alaska Native ancestry. and reside within a designated health service delivery area.

DATE: Written comments must be received on or before October 8. 1986. In addition. public meetings will be held in each of the IHS Areas at which the public will be invited to express their views. These public meetings will be advertised locally and held during the period from the date of publication of this notice to October 8. 1986. The IHS Area and Program offices will send copies of this Notice of Proposed Rulemaking to each tribe within their jurisdiction and invite each tribe to participate in these meetings. We especially invite comments from tribes and tribal organizations regarding how these proposed rules will impact on the eligibility of their members for IHS services.

ADDRESS: Written comments on these proposed rules may be sent to Richard J. McCloskey. Indian Health Service. Room 6A-20. 5600 Fishers Lane. Rockville. Maryland 20857. Comments will be made available for public inspection at this address from 8:30 a.m. to 5:00 p.m. beginning approximately 2 weeks after publication of this notice. The public meetings will be held at times and locations which will be announced by the local IHS Area or Program Office.

FOR FURTHER INFORMATION CONTACT: Richard J. McCloskey. Indian Health Service. Room 6A-20. Parklawn Building. 5600 Fishers Lane. Rockville. Maryland 20857. Telephone 301-443-1116.

SUPPLEMENTARY INFORMATION: Interested persons will have 120 days from publication of this proposed rule. to submit written comments. In addition. within the 120 day comment period. the IHS will hold public meetings at selected locations throughout the country to receive comments on this proposal from Indian and Alaska Native people and others who may be interested. The IHS will inform Indian tribal groups and organizations of. and advertise locally. the dates and places of these meetings. The IHS Area and Program offices will send copies of this Notice of Proposed Rulemaking to each tribe within their jurisdiction and invite each tribe to participate in these meetings. We especially invite comments from tribes and tribal organizations regarding how these proposed rules will impact on the eligibility of their members for IHS services.

The present regulations governing who may receive health services from the IHS are published at 42 CFR 36.12 and 36.23. In order to be eligible for direct services at IHS facilities under § 36.12. a person must be of "Indian descent" and "belong to the Indian community served" by the local IHS health facility and program. No particular degree of Indian ancestry (blood quantum) is required and the term "Indian community" is not defined. The regulations have been construed liberally to include anyone who can reasonably be regarded as an Indian regardless of degree of Indian ancestry or tribal affiliation.

In order to be eligible for contract health services (services purchased from non-IHS hospitals and medical providers) one must meet additional requirements. Under § 36.23. a person must be eligible for direct care from the IHS and in addition reside within a designated contract health services delivery area and be either a member of. or have close social and economic ties with. the tribe located on the reservation. These requirements are more restrictive than those for direct care because contract health services funds are very limited. However. having different requirements for direct and contract services has caused problems when patients at IHS facilities must be referred to non-IHS facilities for needed care.

We propose tightening up eligibility requirements based upon tribal affiliation. degree of Indian ancestry. and residence within a defined geographic service area. This will set limits on the eligible service population enabling us to provide more services within the limited IHS resources available. It will also enable us to allocate resources among beneficiary groups based upon clearly defined local service populations. In addition. substituting more precise eligibility requirements applicable to both direct and contract health services will enhance coordination of patient care in IHS and non-IHS facilities.

Proposed Eligibility Requirements

We propose adding a definition of "Indian and Alaska Native ancestry" meaning descent from a member of an Indian or Alaska Native tribe that has been Federally recognized by treaty or otherwise. This will establish a line of descent for purposes of eligibility. but not all persons of Indian or Alaska Native ancestry will be eligible for IHS services.

With this definition in mind. we propose the following eligibility requirements for IHS services. Persons of Indian or Alaska Native ancestry must:

(1) Be a member of. or eligible for membership in. a Federal recognized Indian tribe: *and*

(2) Be of one quarter (¼) or more Indian or Alaska Native ancestry: *and*

(3) Reside within a designated health service delivery area.

If a person is not a member of. or eligible for membership in. a Federally recognized Indian tribe. then in order to be eligible for IHS services the person must be of one-half (½) or more Indian of Alaska Native ancestry *and* reside within a designated health service delivery area. We propose this exception to the tribal membership requirement to include persons who do not qualify for membership in any one tribe for reasons such as multiple tribal heritage. but who have a high degree of Indian or Alaska Native ancestry.

Blood quantum requirements. as well as tribal membership. have historically been used by Congress. Federal agencies. and the courts to determine who is an "Indian" for purposes of Federal benefits. claims awards. and Federal jurisdiction. There is. however. no uniform Federal standard. We are proposing a one-quarter (¼) blood quantum requirement in addition to tribal membership as a means of achieving fairness and equity across tribal lines. As we note in the discussion of pre-rulemaking activity below. many tribes recommended that we adopt this requirement and we specifically invite comment on this issue.

Furthermore. a one-quarter (¼) degree requirement is consistent with the membership requirements of many tribes. Tribal membership criteria vary. but most tribes have blood quantum requirements for membership. Of the 213 tribal constitutions which we were able to examine at BIA Headquarters, 116 tribes required ¼ or more, 18 required ½ or more, 22 required ⅛ or more, 7 required 1/16 or more, and 58 had no blood quantum requirements as such, but generally required descendency from a member listed on the original tribal roll. In addition, one-quarter (¼) or more Alaska Native blood is generally required for enrollment in Alaska Native corporations.

We have included four exceptions to the above eligibility requirements. These exceptions recognize special circumstances wherein services are provided under current law and regulations:

(1) Persons who meet the above eligibility criteria except for the residency requirement, and who formerly resided within a health service delivery area, may return to their home community within that area and receive direct and contract health services there. This exception includes the minor children of such persons if the children meet the eligibility criteria except for the residency requirement.

(2) The IHS will provide direct and contract health services to a non-Indian woman pregnant with an eligible Indian's child but only during the period of her pregnancy through post-partum (generally about 6 weeks after delivery). In cases where the woman is not married to the eligible Indian under applicable state or tribal law, paternity must be acknowledged in writing by the Indian or determined by order of a court of competent jurisdiction.

(3) The IHS will provide direct and contract health services to non-Indian members of an eligible Indian's household if the medical officer in charge determines that the services are necessary to control acute infectious disease or a public health hazard.

(4) Upon request and with the approval of the service unit director, the IHS may for good cause provide contract health services to an otherwise eligible person for up to 90 days after the person ceases to reside in a health service delivery area.

Our proposal consolidates provisions governing eligibility for contract health services with those for direct services. There are no additional eligibility requirements for contract health services. Provisions are retained allowing the IHS to establish medical priorities for health services, and precluding authorization for contract health services when and to the extent that alternate resources are or should be available and accessible. In addition, contract health services will not be authorized when and to the extent that Indian Health Service facilities are available and accessible to provide the needed care.

The exceptions to the residency requirements for students, transients, and foster children contained in the present regulations are incorporated into a new definition of "reside". Sections 36.24 and 36.25 of the present regulations governing authorization for contract health services and reconsideration and appeals are retained and renumbered as § 36.13 and § 36.14 respectively. As redesignated, § 36.14 governing reconsideration and appeals has been revised so that the reconsideration and appeals process applies to IHS denials of direct as well as contract health services.

Health Service Delivery Areas

We are proposing geographic residency requirements to reflect the IHS obligation to Indians living "on or near" reservations and in traditional Indian areas (Oklahoma and Alaska). We propose deleting § 36.22 of the present regulations designating contract health service delivery areas and substituting a new § 36.15 governing designation of health service delivery areas for both direct and contract health services. The IHS will designate specific geographic areas surrounding Federal Indian reservations as health service delivery areas. Designations will be made by publication of a notice in the **Federal Register** to accompany publication of final regulations.

It is our intention to leave current service delivery areas in place at the outset. Thus, the notice accompanying publication of final regulations will designate health service delivery area boundaries conforming to existing service areas. This will avoid major disruptions in service delivery patterns.

However, it is also our intention to begin a reassessment of service area boundaries based upon the principles enunciated in § 36.15. Some of the current service areas composed of counties including reservation land and bordering on the reservation may have configurations which do not constitute a reasonable service area. This proposed regulation sets forth a procedure under which the IHS, after consultation with the Indian tribes affected, could redesignate the boundaries of any health service delivery area by publication of a notice in the **Federal Register**. Such redesignations would be based upon consideration of specific factors set out in proposed § 36.15.

Our proposal recognizes that in some situations it is inappropriate to use Federal Indian reservations as the basis for defining health service delivery areas. This is the case where reservations are nonexistent or very small and scattered, and the Indian population is widely dispersed. In these situations, the proposed new regulation authorizes the IHS to designate entire states, counties, or census divisions as health service delivery areas. This conforms to present practice. Section 36.22 of the present regulations designates the States of Alaska, Oklahoma and Nevada, as well as certain groups of counties in Minnesota, Wisconsin and Michigan as contract health service delivery areas.

The proposal also allows any Indian tribe located within a health service delivery area to request a change in area boundaries. Requests must be supported by documentation related to the factors IHS must consider in redesignating area boundaries. Tribes will have a right to appeal IHS Area Office determinations on such requests to the IHS Director. See proposed § 36.15(d).

Fee-for-Service Care

We also propose updating the regulation to specify those circumstances in which the IHS may provide direct services at its facilities on a fee-for-service basis. See proposed § 36.12(d). These are:

(1) in emergencies under section 322(b) of the Public Health Service Act, 42 U.S.C. 249(b), and 42 CFR 32.111 of the regulations;

(2) to Public Health Service and other federal beneficiaries under Economy Act (31 U.S.C. 1535) arrangements to the extent that providing services does not interfere with or restrict the provision of services to Indian and Alaska Native beneficiaries;

(3) to non-beneficiaries residing within the health service delivery area under policies approved by the tribe or tribes located on the reservation but only to the extent that providing services does not interfere with or restrict the provision of services to Indian and Alaska Native beneficiaries.

The above provisions governing fee-for-service care reflect current law and policy. They are included here to update the regulations. We note that tightening up the eligibility requirements as proposed will place certain persons, who might have been eligible for free care under the present rules, in the fee-for-service category. The proposed eligibility requirements will not necessarily eliminate the actual provision of services to those individuals who no longer qualify for free care from the IHS. They may still receive services from IHS facilities on a fee-for-service basis under eligibility policies approved by the local tribe(s).

Beneficiary Identification Cards

Proposed § 36.10 requires the IHS, as part of its ongoing registration system, to maintain a list of the names and addresses of persons eligible for services, and to issue beneficiary identification cards as evidence of beneficiary status. This will enable the IHS to have an accurate count of beneficiary populations for purposes of budget allocations. In addition, use of such cards will help local IHS officials identify beneficiaries and carry out other administrative tasks related to admitting patients for treatment. The IHS is presently conducting a registration system so that the administrative process for issuance of beneficiary identification cards is already in place.

Transition

We have not included provisions in this proposal governing the transition from current regulations to new rules. We encourage comments regarding what steps the IHS might take to facilitate that transition for persons who may no longer be eligible under the new rules.

Definitions

Finally we are proposing to delete the definitions in § 36.1 as obsolete, and use the definitions in § 36.21, with certain changes, in a new definitions section for this proposed regulation. The changes are:

(1) Deleting the definition for "contract health service delivery area" and subtituting a definition for "health service delivery area";

(2) Adding a definition of "reside" to mean "living in a locality with the intent to make it a fixed and permanent home", but including exceptions for students, certain transients, and foster children living temporarily away from the service area;

(3) Adding a definition of "Indian or Alaska Native ancestry" as explained above;

(4) Confronting the definition of "Indian tribe" to that contained in the Indian Self-Determination Act, 25 U.S.C. 450b(b); and

(5) Revising the definition of "alternate resources" to clarify that the definition is intended to cover all non-IHS health care providers, institutions, and payment sources but not IHS facilities. Although it is IHS policy not to authorize contract health services when needed care is available and accessible at IHS facilities (see proposed § 36.12(c)), the reference to IHS facilities in the present definition of alternate resources is confusing.

Authority To Issue This Rule

The underlying statutory authority for the IHS program is the Snyder Act, 25 U.S.C. 13. That Act states in pertinent part:

> The Bureau of Indian Affairs, under the supervision of the Secretary of the Interior, shall direct supervise, and expend such moneys as Congress may from time to time appropriate, for the benefit, care, and assistance of the Indians throughout the United States for the following purposes:
>
> * * * * *
>
> For relief of distress and conservation of health.
>
> * * * * *
>
> For the employment of . . . physicians.

This authority, with respect to Indian Health, was transferred to the Secretary of Health and Human Services in 1955. (42 U.S.C. 2001 *et seq.*).

The Supreme Court interpreted the Snyder Act in a landmark case entitled *Morton* v. *Ruiz*, 415 U.S. 199 (1974). The Court noted that "The Snyder Act . . . does not provide eligibility requirements or the details of any program." 415 U.S. at 208. The Court went on to make it very clear that Federal agencies administering Snyder Act programs have the power to define eligibility requirements and limit program benefits in accordance with rational standards. The Court stated:

> Having found that the congressional appropriation was intended to cover welfare services at least to those Indians residing 'on or near' the reservation it does not necessarily follow that the Secretary is without power to create reasonable classifications and eligibility requirements in order to allocate the limited funds available to him for this purpose. (Citations omitted). Thus, if there were only enough funds appropriated to provide meaningfully for 10,000 needy Indian beneficiaries and the entire class of eligible beneficiaries numbered 20,000, it would be incumbent upon the BIA to develop an eligibility standard to deal with the problem; and the standard, if rational and proper, might leave some of the class otherwise encompassed by the appropriation without benefits. But in such a case the agency must, at a minimum, let the standard be generally known so as to assure that it is being applied consistently and so as to avoid both the reality and the appearance of arbitrary denial of benefits to potential beneficiaries. (415 U.S. at 231–32).

The *Ruiz* decision reconciles the power of the administering Federal agency to limit Snyder Act program benefits through adoption of rational eligibility requirements with the trust responsibilities of the Federal Government toward Indians. The Court viewed the trust responsibility as requiring the Federal agency to deal fairly with Indians, *i.e.*, "promulgate eligibility requirements according to established procedures." 415 U.S. at 237.

Paperwork Reduction Act

Proposed § 36.12, § 36.14, § 36.15(d) and § 36.16, contain information collection requirements. As required by § 3504(h) of the Paperwork Reduction Act of 1980, we have submitted a copy of this proposed rule to the Office of Management and Budget (OMB) for its review of these information collection requirements. Other organizations and individuals desiring to submit comments on the information collection requirements should direct them to the agency official designated for this purpose whose name appears in this preamble, and to the Office of Information and Regulatory Affairs, OMB, New Executive Office Building (Room 3208), Washington, DC 20503, ATTN: Desk Office for HHS.

Pre-Rulemaking Activity

The current regulation dealing with Indian eligibility for IHS programs has been a topic of discussion for many years both within the Indian community and IHS. On June 6, 1983, we published a notice in the **Federal Register** (48 FR 25273) asking for comments on a number of options for eligibility criteria. We received a total of 242 responses: 28 from tribal governments, 4 from tribal organizations, 15 from other Indian organizations, 4 from other organizations, and 191 from individuals. The comments from individuals generally supported retention of current eligibility requirements. The comments from tribal groups generally supported use of a blood quantum requirement for IHS eligibility, but expressed concern that we try to avoid hardship in localities where unemployment is a problem and no other health insurance exists. The majority of the tribes responding stated that if we adopt a blood quantum criterion, that it be one-quarter (¼) blood.

This proposed rule does not have cost implications for the economy of $100 million or more independent of the IHS appropriation, nor will it result in a major increase in cost for consumers, industries, or Government agencies, nor will it adversely affect competition. Therefore, the Secretary has determined that the rule is not a "major rule" under Executive Order 12291, and a regulatory imapct analysis is not required. Further, these regulations will not have a significant economic impact on a substantial number of small entities, and therefore do not require a regulatory flexibility analysis under the Regulatory Flexibility Act of 1980.

List of Subjects in 42 CFR Part 36

Alaska natives, Indians, Health, Health facilities, Health service delivery areas, Contract health services.

Dated: January 27, 1986.

Donald Ian Macdonald,

Acting Assistant Secretary for Health.

Approved: May 19, 1986.

Otis R. Bowen,

Secretary.

PART 36—[AMENDED]

For the reasons set out in the preamble, we propose amending Subparts A, B and C of 42 CFR Part 36 as follows:

1. The authority citation for Part 36 continues to read as follows:

Authority: Sec. 3, 68 Stat. 674; 42 U.S.C. 2003, 42 Stat. 208, sec. 1, 68 Stat. 674; 25 U.S.C. 13, 42 U.S.C. 2001 unless otherwise noted.

2. Subpart A is amended by revising the title, removing § 36.1, and redesignating §§ 36.2 and 37.3 as §§ 36.1 and 36.2 respectively, to read as follows:

Subpart A—Purpose

36.1 Purpose of the regulation.

* * * * *

36.2 Administrative instructions.

* * * * *

3. Subparts B and C are amended by

A. Redesignating § 36.12(c) as § 36.11(d).

B. Revising § 36.12.

C. Revising and redesignating § 36.21 as § 36.10.

D. Redesignating § 36.24 as § 36.13.

E. Removing § 36.14 and by revising paragraph (a) introductory text of § 36.25 and then by redesignating § 36.25 as § 36.14. The revised paragraph (a) introductory text would read as set forth below, and

F. Adding new §§ 36.15 and 36.16 to read as set forth below. The revised and added portions of Subpart B read as follows:

§ 36.10 Definitions.

As used in this subpart:

(a) "Alternate resources" means resources other than those of the Indian Health Service available and accessible to the individual, such as health care providers and accessible to the individual, such as health care providers and institutions, health care payment sources, or other health care programs for the provision of health services, (e.g., medicare, medicaid, State or local health care programs or private insurance) for which the individual may be eligible or would be eligible except for the existence of the IHS contract health services program.

(b) "Appropriate ordering official" means, unless otherwise specified by contract with the health care facility or provider, the ordering official for the health service delivery area in which the individual requesting contract health services or on whose behalf the services are requested, resides.

(c) "Area Director" means the Director of an Indian Health Service area designated for purposes for administration of Indian Health Service Programs.

(d) "Contract health services" means health services provided at the expense of the Indian Health Service from public or private medical or hospital facilities other than those of the Service.

(e) "Emergency" means any medical condition for which immediate medical attention is necessary to prevent the death or serious impairment of the health of an individual.

(f) "Health service delivery area" means a geographic area designated pursuant to § 36.15 of this Subpart.

(g) "Indian or Alaska Native ancestry" means descent from a member of an Indian or Alaska Native tribe that has been Federally recognized by treaty or otherwise.

(h) "Indian tribe" means any Indian tribe, band [illegible]on, or other organized group or community, including any Alaska Native village or regional or village corporation as defined in or established pursuant to the Alaska Native Claims Settlement Act, 43 U.S.C. 1601 *et. seq.*, which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.

(i) "Program Director" means the Director of an Indian Health Service "program area" designated for the purposes of administration of Indian Health Service programs.

(j) "Reservation" means any Federally recognized Indian tribes, reservation, Pueblo, or colony, including former reservations in Oklahoma, Alaska Native regions established pursuant to the Alaska Native Claims Settlement Act (43 U.S.C. 1601 *et seq.*), and Indian allotments.

(k) "Reside" means living in a locality with the intent to make it a fixed and a permanent home. The following persons will be deemed residents of the health service delivery area:

(1) Students who are temporarily absent from the health service delivery area during full time attendance at programs of vocational, technical, or academic education including normal school breaks;

(2) Persons who are temporarily absent from the health service delivery area for purposes of travel or employment (such as seasonal or migratory workers);

(3) Indian children placed in foster care outside the health service delivery area by order of a court of competent jurisdiction and who were residents within the service area at the time of the court order.

(l) "Secretary" means the Secretary of Health and Human Services and any other officer or employee of the Department of Health and Human Services to whom the authority involved has been delegated.

(m) "Service" means the Indian Health Service.

(n) "Service Unit Director" means the Director of an Indian Health Service "Service unit area" designated for purposes of administration of Indian Health Service programs.

§ 36.12 Persons to whom health services will be provided.

(a) Subject to the requirements of this Subpart, the Indian Health Service will provide direct services at its facilities, and contract health services, as medically indicated, and to the extent that funds and resources allocated to the particular health service delivery area permit, to persons of Indian and Alaska Native ancestry who:

(1) Are members of, or eligible or membership in, a federally recognized Indian tribe; *and*

(2) Are of one quarter (¼) or more Indian or Alaska Native ancestry as determined by the Department of the Interior or through other reasonable means; *and*

(3) Reside within a health service delivery area designated under § 36.15 of this part; *or*

(4) Are not members of, or eligible for membership in, a Federally recognized Indian tribe but are of one half (½) or more Indian or Alaska Native ancestry and reside within a health service delivery area designated under § 36.15 of this part.

(b) Subject to the requirements of this Subpart, the Indian Health Service will also provide direct services at its facilities and contract health services, as medically indicated, and to the extent that funds and resources allocated to the particular health service delivery area permit, in the circumstances listed below:

(1) Persons who meet the eligibility criteria in paragraph (a) of this section except for the residency requirement, who formerly resided within a health service delivery area designated under

§ 36.15 of this part, and who return to their home community within that area and receive services there (and minor children of such persons if the children meet the eligibility criteria in paragraph (a) of this section except for the residency requirement).

(2) A non-Indian woman pregnant with an eligible Indian's child but only during the period of her pregnancy through post-partum (generally about 6 weeks after delivery). In cases where the woman is not married to the eligible Indian under applicable state or tribal law, paternity must be acknowledged in writing by the Indian or determined by order of a court of competent jurisdiction.

(3) Non-Indian members of an eligible Indian's household if the medical officer in charge determines that the health services are necessary to control acute infectious disease or a public health hazard.

(4) Upon request and with the written approval of the Service Unit Director for good cause, to an otherwise eligible person for up to 90 days after the person ceases to reside in a health service delivery area.

(c) Contract health services will not be authorized when and to the extent that Indian Health Service facilities are available and accessible to provide the needed care. When funds are insufficient to provide the volume of contract health services needed by the service population, the Indian Health Service shall determine service priorities on the basis of medical need. Contract health services will not be authorized when, and to the extent that, alternate resources for payment:

(1) Are available and accessible to the beneficiary, or

(2) Would be available and accessible if the beneficiary were to apply for them, or

(3) Would be available and accessible under state or local law or regulation in the absence of the individual's eligibility for contract health services from the Indian Health Service.

(d) The Indian Health Service may provide direct services at its facilities on a fee-for-service basis to persons who are not beneficiaries under paragraphs (a) and (b) of this section in any of the following circumstances:

(1) In emergencies under section 322(b) of the Public Health Service Act, 42 U.S.C. 249(b), and 42 CFR 32.111.

(2) To Public Health Service and other Federal beneficiaries under Economy Act (31 U.S.C. 1535) arrangements to the extent that providing services does not interfere with or restrict the provision of services to Indian and Alaska Native beneficiaries:

(3) To non-beneficiaries residing within the health service delivery area when approved by the tribe or tribes located on the reservation but only to the extent that providing services does not interfere with or restrict the provision of services to Indian and Alaska Native beneficiaries.

§ 36.14 Reconsideration and appeals.

(a) Any person who has asked for and been denied health services by the Indian Health Service or by a tribal organization under the Indian Self-Determination Act, shall be notified of the denial in writing together with a statement of the reasons for the denial. The notice shall advise the applicant that within 30 days from the receipt of the notice the applicant:

(1) * * *

* * * * *

§ 36.15 Health service delivery areas.

(a) The Indian Health Service will designate and publish as a notice in the **Federal Register** specific geographic areas including Federal Indian reservations and areas surrounding those reservations as health service delivery areas.

(b) The Indian Health Service may, after consultation with the Indian tribes affected, redesignate the boundaries of any health service delivery area by publication of a notice in the **Federal Register**. Any redesignation of a health service delivery area will include the reservation, and those areas close to the reservation boundaries which can reasonably be considered part of the reservation service area based on consideration of the following factors:

(1) The number of persons residing in the off-reservation area who would be eligible under § 36.12(a) (1), (2), and (4).

(2) Whether the governing body of the tribe(s) on the reservation treats those persons as an integral part of the reservation tribal community:

(3) The number of persons residing in the off-reservation area who have traditionally received health services from the Indian Health Service and whose eligibility for services would be affected:

(4) The geographic proximity of the off-reservation area to the reservation.

(5) Whether the Indians residing in the off-reservation area can be expected to need and to use health services provided by the Indian Health Service given the alternate resources (health facilities and payment sources) available and accessible to them.

(c) Notwithstanding paragraphs (a) and (b) of this section above, the Indian Health Service may designate States, subdivisions of States such as counties or towns, or other identifiable geographic areas such as census divisions, as health service delivery areas where reservations are nonexistent, or so small and scattered and the Indian population so widely dispersed that it is inappropriate to use reservations as the basis for defining the health service delivery area.

(d) Any Indian tribe located within a health service delivery area may, by resolution of the tribal governing body, request a change in area boundaries. Such a request should be supported by documentation related to the factors for consideration set out in paragraph (b) of this section. The Indian tribe will be afforded the opportunity to express its views orally and in writing first to the appropriate IHS Area or Program Director, and then to the IHS Director or the Director's designee prior to any IHS decision. The decision of the IHS Director shall constitute final agency action on the tribe's request. Changes in the boundaries of health service delivery areas will be published in the **Federal Register**.

§ 36.16 Beneficiary identification cards.

The Indian Health Service, as part of its ongoing registration system, will maintain a list of the names and addresses of persons who are eligible for services under § 36.12(a), and will issue beneficiary identification cards as evidence of beneficiary status. Persons requesting beneficiary identification cards must submit evidence of tribal membership, Indian blood quantum, and residence within a health service delivery area. Questions regarding triba membership of Indian blood quantum will be resolved through consultation with the appropriate tribe and officials of the Bureau of Indian Affairs.

4. Subpart C is amended by removing §§ 36.22 and 36.23 and reserving the Subpart to read as follows:

Subpart C—[Reserved]

[FR Doc. 86-13047 Filed 6-9-86; 8:45 am]

BILLING CODE 4160-16-M

ATTACHMENT - 4

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Public Health Service

42 CFR Part 36

Indian Health Services; Eligibility, Extension of Comment Period

AGENCY: Public Health Service, HHS.

ACTION: Proposed rule; extension of comment period.

SUMMARY: The Department of Health and Human Services (HHS) is extending the comment period on a proposal to revise the regulations governing who may receive health services from the Indian Health Service (IHS). The extension is being made because of great interest exprassed in this proposal by affected individuals, Tribal governments and the Congress, and in response to a number of specific requests for additional time in order to accommodate previously scheduled meetings of tribes and Indian organizations. It is our desire that all interested parties have ample time to express their views on this proposal.

DATE: In order to assure consideration in the development of any final rule, written comments must be received on or before November 7, 1986.

ADDRESS: Written comments should be sent to Richard J. McCloskey, Indian Health Service, Room 6A–20, 5600 Fishers Lane, Rockville, Maryland, 20857. Comments received may be seen in the above office between 9:00 a.m. and 4:00 p.m. Monday through Friday.

FOR FURTHER INFORMATION CONTACT: Richard J. McCloskey, Indian Health Service, Room 6A–20, 5600 Fishers Lane, Rockville, Maryland, 20857, Telephone (301) 443-1116 (This is not a toll free number).

SUPPLEMENTARY INFORMATION: In the Federal Register of June 10, 1986 (51 FR 21118), HHS proposed to revise the regulations in 42 CFR Subparts A, B, and C which govern who may receive health services from IHS Under that proposal an eligible person would have to be: (1) A member of, or eligible for membership in, a Federally recognized tribe, (2) of one-quarter (¼) or more Indian or Alaska Native ancestry, and (3) reside within a designated health service delivery area. If the person is not a member of, or eligible for membership in, a federally recognized Indian tribe, then the person would have to be of one-half (½) or more Indian or Alaska Native ancestry, and reside within a designated health service delivery area.

Interested persons were given until October 8, 1986 to comment on the proposed rule. In addition, during this 120 day comment period, the IHS was to hold public meetings at selected locations throughout the country to receive comments on the proposal. Over 90 such meetings have been held.

A large number of public comments have been received and most meetings have been well attended. In addition, comments have been received from members of Congress, Congressional Committees, as well as State and local officials. All these are indicative of both intense interest and the controversial nature of portions of the proposal. Eligibility criteria for governmental programs are, by their nature, sensitive. This proposal is also complex in that it attempts to deal with conditions that vary widely across the country and proposes changes in regulations most of which have been in effect for almost 30 years. In addition, we have received a number of specific requests from Indian tribes and organizations that the comment period be extended to cover the time of meetings which had been scheduled long before the publication of the proposal. The Indian tribes and organizations have not only expressed their concern that their members have this opportunity to express their views but also that the Indian tribes or organizations themselves need this input to formulate their comments.

Therefore, interested persons may, on or before November 7, 1986, submit written comments on the proposed rule to the above address. Comments may be submitted after this date but, though we shall make every effort to consider such comments before any final determinations are made, no assurance can be given that they will be processed in time to be acted upon.

Approved: October 8, 1986.

Robert E. Windom,
Assistant Secretary for Health.

Otis R. Bowen,
Secretary.

[FR Doc. 86-23008 Filed 10-9-86; 1:16 pm]

BILLING CODE 4160-16-M

MHA
MONTANA HOSPITAL ASSOCIATION
1720 NINTH AVENUE • P.O. BOX 5119
HELENA, MT 59604 • (406) 442-1911

MONTANA HOSPITAL ASSOCIATION

testimony of
Gerald Bibo
before the

SENATE SPECIAL
COMMITTEE ON
INDIAN AFFAIRS

JUNE 21, 1988

MONTANA HOSPITAL ASSOCIATION
TESTIMONY OF GERALD BIBO BEFORE THE
SENATE SPECIAL COMMITTEE ON INDIAN AFFAIRS

JUNE 21, 1988

MR. CHAIRMAN, MEMBERS OF THE COMMITTEE, I AM GERALD BIBO, CHAIRMAN OF THE MONTANA HOSPITAL ASSOCIATION, AND PRESIDENT OF NORTHERN MONTANA HOSPITAL IN HAVRE, MONTANA. HAVRE IS LOCATED MID-WAY BETWEEN THE ROCKY BOY INDIAN RESERVATION AND THE FORT BELKNAP INDIAN RESERVATION. MY HOSPITAL IS ONE OF ELEVEN HOSPITALS IN THE STATE WHICH PROVIDE CONTRACT HEALTH SERVICES TO INDIAN PEOPLE. THERE ARE SEVEN INDIAN RESERVATIONS IN MONTANA, AND THREE INDIAN HEALTH SERVICE HOSPITALS. THE FINAL RULES PROMULGATED BY THE DEPARTMENT OF HEALTH AND HUMAN SERVICES ON SEPTEMBER 16, 1987 TO CHANGE ELIGIBILITY CRITERIA UNDER WHICH INDIANS ARE ELIGIBLE FOR INDIAN HEALTH SERVICE ARE OBVIOUSLY OF CONCERN TO US.

THE MONTANA HOSPITAL ASSOCIATION SUPPORTS SENATE BILL 2382, WHICH WOULD DELAY FOR A PERIOD OF THREE YEARS THE IMPLEMENTATION OF THESE RULES. WE BELIEVE THAT THE MORATORIUM ON IMPLEMENTATION WILL PROVIDE AN OPPORTUNITY TO STUDY THE FINANCIAL, SOCIAL AND CULTURAL IMPLICATIONS OF THE PROPOSED CHANGES.

AS A CONTRACT PROVIDER OF HEALTH SERVICES TO INDIAN PATIENTS, I AM, OF COURSE, CONCERNED ABOUT THE ECONOMICS OF THE NEW RULES. THE INDIAN HEALTH SERVICE DID NOT PERFORM A REGULATORY IMPACT ANALYSIS AS REQUIRED BY EXECUTIVE ORDER 12291, BECAUSE IT DID NOT CONSIDER THE PROPOSAL A MAJOR RULE.

IHS CLAIMS THAT THE RULE "DOES NOT HAVE COST IMPLICATIONS FOR THE ECONOMY OF $100 MILLION OR MORE INDEPENDENT OF THE IHS APPROPRIATION, NOR WILL IT RESULT IN A MAJOR INCREASE IN COST FOR CONSUMERS, INDUSTRIES, OR GOVERNMENT AGENCIES, NOR WILL IT ADVERSELY AFFECT COMPETITION."

WHILE THE OVERALL EFFECT OF THE RULE MAY NOT HAVE COST IMPLICATIONS FOR THE ECONOMY OF $100 MILLION OR MORE, IT NEVERTHELESS WILL HAVE AN IMPACT ON A SMALL STATE WITH A NUMBER OF SMALL PROVIDERS. LET ME EXPLAIN. THE SEVEN SMALLEST CONTRACT PROVIDERS IN MONTANA AVERAGE 40 BEDS. THE REMAINING FOUR FACILITIES, WHICH ARE SECONDARY REFERRAL CENTERS, AVERAGE ONLY 167 BEDS PER FACILITY.

I WOULD LIKE TO CONCENTRATE FOR A MOMENT ON THE SMALLER HOSPITALS. PRIOR TO OCTOBER 1, 1987 THESE HOSPITALS WERE REIMBURSED ON THE BASIS OF CHARGES FOR IHS SERVICES. AFTER OCTOBER 1, THEY AGREED TO BE REIMBURSED ON THE BASIS OF DIAGNOSTIC RELATED GROUPS (OR DRGS) AT RATES THAT, FOR MOST, WOULD NOT EXCEED THE AMOUNTS PAID BY MEDICARE FOR SIMILAR CARE. THIS CHANGE IN PAYMENT METHODOLOGY WAS ESTABLISHED TO LIMIT AND CONTROL IHS CONTRACT HEALTH EXPENDITURES. IN EFFECT IT SHIFTED THE RISK AND COST OF UNUSUALLY LONG-TERM OR EXPENSIVE CARE FROM IHS TO THE HOSPITAL. IF A HOSPITAL SHOULD TREAT A PATIENT WHOSE CARE IS UNUSUALLY EXPENSIVE OR WHOSE LENGTH-OF-STAY IS UNUSUALLY LONG (KNOWN AS AN OUTLIER), OR IF THERE IS A DECREASE IN MEDICARE OR IHS PAYMENTS BELOW COST, OR IF THE AMOUNT OF BAD

DEBTS AND CHARITY CARE INCREASES, THE HOSPITAL HAS NO CHOICE BUT TO SHIFT THE COSTS FROM THOSE WHO DON'T OR CAN'T PAY TO THOSE WHO WILL, IN ORDER TO SURVIVE, OR NOT DOWNGRADE SERVICES. THIS GENERALLY MEANS THE SELF PAYING PATIENTS, AND THOSE WHO PAY THE PREMIUMS OF COMMERCIAL INSURERS, WILL ABSORB THESE COSTS.

IHS IS OF COURSE NOT THE ONLY PAYER THAT REIMBURSES ON THE BASIS OF DRGS. IN MONTANA, BOTH MEDICARE AND MEDICAID ALSO REIMBURSE WITH DRGS. THE HOSPITAL IN POPLAR, MONTANA IS A 22 BED FACILITY THAT SITS ON THE FORT PECK INDIAN RESERVATION. WITH THE TOTAL OF IHS, MEDICARE AND MEDICAID, POPLAR COMMUNITY HOSPITAL IS 90 PERCENT DRG-UTILIZED. ADDITIONALLY, OF THE REMAINING 10 PERCENT, BAD DEBTS AND CHARITY ACCOUNT FOR ABOUT 3 PERCENT. WHAT THIS MEANS IS THAT ANY UNREIMBURSED COST FROM 93 PERCENT OF THE PATIENTS MUST BE SHIFTED TO THE 7 PERCENT WHO CAN PAY. IN PRACTICAL TERMS, POPLAR COMMUNITY HOSPITAL MUST RAISE CHARGES $14 IN ORDER TO MAKE $1. IT IS OBVIOUSLY IMPOSSIBLE TO SUCCESSFULLY SHIFT COSTS TO PRIVATE PAYERS. WHEN RATES BECOME TOO HIGH, PEOPLE SEEK CARE ELSEWHERE. THEREFORE, THE HOSPITAL IS VERY SENSITIVE TO ANY CHANGES IN PAYMENT. IF THIS RULE WOULD INCREASE THE NUMBER OF BAD DEBTS ONLY SLIGHTLY, IT WOULD CREATE A RIPPLE EFFECT. SHOULD THE HOSPITAL CLOSE, THE IHS ELIGIBLE PEOPLE AT FORT PECK WOULD BE SIGNIFICANTLY EFFECTED. THERE IS NO IHS HOSPITAL ON THE RESERVATION.

A SECOND AREA OF CONCERN HAS TO DO WITH MEDICAID. I AM FEARFUL THAT A SIGNIFICANT PORTION OF THOSE WHO LOSE IHS BENEFITS WILL SEEK

COVERAGE FROM MEDICAID. THE MEDICAID SYSTEM IN MONTANA, AS I SAID EARLIER, IS A FIXED-RATE DRG SYSTEM. OUR FEDERAL MATCH IS ABOUT 70 PERCENT. MONTANA'S ECONOMY AND TAX BASE IS STRESSED. WE DO NOT ANTICIPATE THAT THE STATE LEGISLATURE WILL FUND THE MEDICAID PROGRAM AT LEVELS MUCH HIGHER THAN THEY ARE CURRENTLY. IF THE NUMBER OF MEDICAID ELIGIBLES RISES AT THE SAME TIME THAT COSTS ARE RISING, THE TRUE COST OF THE MEDICAID SYSTEM WILL OUTSTRIP THE ABILITY OF THE STATE TO PAY FOR THOSE SERVICES. THE MEDICAID BUREAU WILL REACT IN ONE OF TWO WAYS. IT WILL LOWER PAYMENTS TO PROVIDERS, OR IT WILL REDUCE THE NUMBER OF PEOPLE ELIGIBLE. LOWER PAYMENTS MEAN COST SHIFTING. REDUCED ELIGIBILITY MEANS GREATER BAD DEBTS AND CHARITY, WHICH ALSO TRANSLATES INTO COST SHIFTING. I'VE ALREADY EXPLAINED THE DIFFICULTIES OF COST SHIFTING.

WE ARE NOT AT ALL SURE WHAT WILL HAPPEN TO THE NUMBER OF ELIGIBLES UNDER THE NEW RULES. THE BILLINGS AREA INDIAN HEALTH SERVICE OFFICE ESTIMATES THAT THE RULES WILL MAKE 4,000 PEOPLE WHO ARE CURRENTLY ELIGIBLE FOR BENEFITS, INELIGIBLE FOR THEM, BUT WILL MAKE INELIGIBLE SOME 8,300 PEOPLE WHO ARE PRESENTLY RECEIVING BENEFITS. THESE STATISTICS SEEM TO INDICATE A NET REDUCTION IN ELIGIBILITY OF 4,300 PEOPLE. THE TRIBES LOCATED BY OUR HOSPITAL, CHIPPEWA CREE TRIBE AT ROCKY BOY, 25 MILES SOUTH OF TOWN, ROCKY STUMP, CHAIRMAN, AND FT. BELKNAP INDIAN COMMUNITY, 40 MILES EAST OF TOWN, GILBERT HORN, CHAIRMAN, ESTIMATE A LOSS OF ELIGIBILITY BECAUSE OF THESE RULES -- 230 PEOPLE AT ROCKY BOY IN HILL COUNTY, AND 1,000 AT FT. BELKNAP WITHIN LANE AND PHILIPS COUNTY. IHS SUGGESTS THAT THE PEOPLE WHO HAVE BEEN EXCLUDED FROM COVERAGE USE THE TRANSITION PERIOD TO FIND ALTERNATIVE COVERAGE.

THE OPTIONS AVAILABLE FOR ALTERNATIVE COVERAGE ARE COMMERCIAL INSURANCE OR MEDICAID. BOTH COMMERCIAL INSURANCE AND MEDICAID ARE CONSIDERED PRIMARY INSURANCE UNDER EXISTING IHS RULES. IN OTHER WORDS, IF AN INDIAN PERSON HAS COMMERCIAL INSURANCE OFFERED THROUGH AN EMPLOYER, THAT INSURANCE PAYS FIRST AND IHS PAYMENTS ARE ACTIVATED ONLY AFTER COMMERCIAL INSURANCE BENEFITS HAVE BEEN EXHAUSTED. THE SAME IS TRUE OF MEDICAID. IT DOESN'T SEEM LIKELY THAT THERE WILL BE A TREMENDOUS INCREASE IN THE AVAILABILITY OF COMMERCIAL INSURANCE TO INDIAN PEOPLE. MOST COMMERCIAL INSURANCE IS EMPLOYER-RELATED. THE ONLY WAY COMMERCIAL INSURANCE COVERAGE IS GOING TO INCREASE IS BY A SIGNIFICANT CHANGE IN EMPLOYMENT OPPORTUNITY. THE RESERVATIONS LOCATED BY NORTHERN MONTANA HOSPITAL HAVE A 75% UNEMPLOYMENT RATE. THOSE WHO HAVE JOBS WHICH OFFER HEALTH INSURANCE ALREADY HAVE IT AS THE PRIMARY INSURER. HOWEVER, EMPLOYER-SPONSORED HEALTH INSURANCE DOES NOT NECESSARILY HAVE PROVISIONS FOR EYEGLASSES, DENTAL CARE, DIABETIC CLINICS, AND SO FORTH. THESE SERVIES ARE PAID FOR OUT-OF-POCKET. THOSE INDIAN PEOPLE WHO DON'T HAVE JOBS, OR WHO HAVE JOBS WHICH DO NOT HAVE A HEALTH INSURANCE BENEFIT, AND WHO STAND TO LOSE IHS BENEFITS WILL NOT BE ABLE TO "PICK UP" COMMERCIAL INSURANCE. THESE PEOPLE WILL HAVE TO RELY ON MEDICAID AND, IF THEY ARE FOUND TO BE CATEGORICALLY INELIGIBLE FOR MEDICAID, THEY WILL BECOME PART OF THE HOSPITAL'S INDIGENT CARE POPULATION. . . MEANING NO MONEY FOR SERVICES RENDERED.

WHAT IS THE IMPACT OF THIS PROPOSED RULE ON PROVIDERS OF CONTRACT SERVICES? I CAN NOT SAY, FOR SURE. THERE REMAINS TOO MANY UNANSWERED QUESTIONS. THE HOSPITALS THAT HAVE SIGNED CONTRACTS WITH IHS, AND WE ARE ONE, HAVE EXPRESSED THEIR WILLINGNESS TO WORK TOGETHER WITH IHS TO IMPROVE THE HEALTH OF INDIAN PEOPLE. IN FACT, WHEN WE SUBMITTED OR CONTRACT BID, WE SPECIFICALLY WROTE:

1. THE HOSPITAL AND ITS PHYSICIANS HAVE DEEP CONCERN AS TO THE QUALITY OF AND ACCESS TO CARE FOR NATIVE AMERICANS NEEDING CARE.

2. THE PHYSICIANS ON THE HOSPITAL STAFF, AND THOSE AT THE CLINICS ON THE RESERVATIONS, SHOULD DETERMINE THE TYPE AND NEED FOR SERVICES TO BE RENDERED.

3. THE NEEDS OF INDIAN PATIENTS AND THEIR FAMILIES SHOULD BE CONSIDERED FIRST BEFORE BEING DISLODGED FROM THEIR FAMILY ENVIRONMENT TO BE SENT TO OTHER FACILITIES ELSEWHERE WHEN SERVICES COULD BE PROVIDED BY LOCAL PHYSICIANS THEY KNOW AND CLOSE TO HOME.

4. PLANNING FOR CURRENT AND FUTURE DELIVERY OF HEALTH CARE SERVICES AT FT. BELKNAP AND ROCKY BOY SHOULD INCLUDE THE INVOLVEMENT OF NORTHERN MONTANA HOSPITAL, THE PHYSICIAN OF THE AREA, AND THOSE RESPONSIBLE FOR THE HOSPITAL'S PLANNING, IF EFFICIENCIES ARE TO BE ACHIEVED FOR THE BENEFIT OF ALL INVOLVED.

5. DIALOGUE WILL CONTINUE BETWEEN THE MEDICAL COMMUNITY AND THE NATIVE AMERICAN COMMUNITIES THROUGH JOINT LEADERSHIP MEETINGS.

IN RETURN FOR OUR COOPERATION, WE ASK THAT IHS CONSIDER THE INTERRELATIONSHIP OF ELIGIBILITY AND THE FINANCIAL HEALTH OF CONTRACT AND NON-CONTRACT FACILITIES. THE MONTANA HOSPITAL ASSOCIATION BELIEVES THAT AT THE VERY LEAST A REGULATORY IMPACT ANALYSIS ON THESE RULES SHOULD HAVE BEEN PERFORMED, AND STILL NEEDS TO BE PERFORMED.

HEALTH CARE SERVICES FOR INDIANS AND PEOPLE IN RURAL AMERICA ARE ALIKE IN MANY WAYS. THE SURVIVAL OF INSTITUTIONS TO CARE FOR THEM WILL DETERMINE WHETHER THEY HAVE ACCESS TO QUALITY HEALTH CARE SERVICES, OR ARE RELEGATED TO THE STATUS OF SECOND CLASS CITIZENS. I DO NOT BELIEVE THAT MOST PEOPLE IN THIS COUNTRY WANT A TWO-TIERED MEDICAL SYSTEM.

FINALLY, I WOULD LIKE TO REITERATE OUR SUPPORT OF SENATE BILL 2382 AND THANK THE COMMITTEE FOR THE OPPORTUNITY OF APPEARING BEFORE YOU TODAY.

The Montana Hospital Association is a trade association comprised of fifty-eight community and federal hospitals. The Association has served the interests of Montana hospitals for over 53 years.

The Montana Hospital Association is a member of the Northwest Network, a coalition of hospital associations, which serves as a regional voice for rural hospitals in Idaho, Montana, Oregon and Washington.

NATIONAL INDIAN HEALTH BOARD
50 South Steele Street, Suite 500
Denver, Colorado 80209
(303) 394-3500

STATEMENT ON S. 2382, A BILL TO DELAY THE EFFECT OF THE IHS ELIGIBILITY RULE

presented by

The National Indian Health Board
June 21, 1988

Mr. Chairman, distinguished members of the Indian Affairs Committee, I am Jake Whitecrow, a member of the Quapaw and Seneca-Cayuga Tribes of Oklahoma. I served in the 1970's on the American Indian Policy Review Commission, and I have more than 30 years of experience working with Indian programs. I am appearing before you today on behalf of the National Indian Health Board, a private non-profit corporation based in Denver, Colorado, whose Board of Directors is comprised of elected tribal officials from each of the 12 geographic service regions of the Indian Health Service (IHS). NIHB is committed to improving the health status of all American Indians and Alaska Natives, and we work closely with Area Health Boards, Inter-Tribal Councils, Tribal Health Departments, national Indian organizations, and other interested parties in fulfillment of our mission.

On behalf of the NIHB Board of Directors, I wish to express my appreciation to the Committee for this opportunity to express our views on Senate Bill 2382, which addresses the crucial issue of eligibility for health care funded by the Indian Health Service.

The National Indian Health Board offers its full support for Senate Bill 2382, and we urge that this Committee seek prompt passage for this important piece of legislation in order to insure that health services continue to be provided to all American Indians and Alaska Natives that presently qualify for such care.

Over the past eight years, Indian Tribes have been forced to endure a series of efforts designed to reduce the scope of services and programs available to Indian people. No where has this effort been more pronounced than in the area of Indian health care, where we have seen repeated attempts to reduce or eliminate services that are essential to the provision of quality medical care to our people. If not for the support of Congress -- and in particular the work of this Committee -- the Indian health care system as we know it would surely have been dismantled, and the remarkable progress that has been achieved in improving the health status of our people over the past 30 years would have been reversed.

The most striking example of these proposals to undermine the Indian health program is the issue before this Committee today: the effort to redefine who is eligible for health care services funded by the Indian Health Service. In the early 1980's, this recommendation first surfaced in a report issued by the Grace Commission, which concluded that 20 percent of the IHS service population could be eliminated through the issuance of new eligibility regulations requiring Indian beneficiaries to be members of Federally recognized Tribes and have at least one-quarter degree

Indian blood. Such a change, the Commission held, would lead to an annual savings of $60-70 million in the IHS budget.

That initial budget-driven proposal marked the beginning of what has since become one of the most emotional debates in Indian Country in recent years. After hundreds of hearings and meetings in Indian communities around the country -- which led to thousands of comments opposing such changes -- the Department of Health and Human Services issued a final rule September 16, 1987 that specified new eligibility criteria for the Indian Health Service. The reaction to these new regulations, as Senator Melcher so aptly observed in introducing S. 2382, has been a "firestorm" of protest throughout Indian Country.

This protest, in my view, is the result of (1) the perception that this rule is yet another attempt to weaken the Federal government's trust responsibility to Indians; (2) the threat of terminating health services to individual Indians -- such as the elders, the handicapped -- that are most in need and have no other source of health care; (3) the fact that Tribes were not provided adequate data about the potential impact of the rule; and (4) the belief that the new eligibility rule is a direct infringement on the sovereign right of Tribal governments to determine for themselves who is eligible for services.

Tribal objections to the new IHS eligibility rule have been evident at virtually every major regional and national Indian meeting during the past nine months. For example, at a national meeting on Indian health issues in Nashville, TN last month, some 300 tribal representatives voiced unanimous support for a resolution calling for the immediate withdrawl of the eligibility rule and urging congressional intervention to prohibit any further implementation of the new guidelines. That resolution (which is included in my written statement as an attachment) has since been endorsed by a number of tribal councils nationwide.

One of the most compelling factors that led to the passage of the resolution in Nashville was the clear indication from tribal representatives about the different consequences this rule would have in various regions of the country. In IHS Areas such as California and Alaska, the Indian service population would be reduced drastically: California representatives have projected that as many as 50,000 Indians in that state would lose their eligibility, while in Alaska as much as 15 percent of the current Native population would be rendered ineligibile. We are extremely pleased to hear that this Committee will be conducting separate hearings in these two areas to examine the unique problems involved in the eligibility question there.

In other IHS regions -- such as the Phoenix Area and the United South and Eastern Tribes (USET) Area -- the rule is projected to have an opposite effect: more Indians will become eligible, especially for contract care services, and there has been no indication that additional funds will be made available to address this additional demand. IHS is already faced with a staggering shortage in contract care dollars, with more than $64 million reported in "deferred services" for the current fiscal year. We simply cannot afford to add to this amount.

The disparities in how the IHS eligibility rule is projected to affect the Indian population illustrate how unwise it would be to permit this rule to go into effect. From the beginning of this controversy over the IHS eligibility rule, the National Indian Health Board has taken the position that before any change can be made there must first be an Area-by-Area impact analysis conducted in full cooperation with Tribal governments (a copy of our position is attached). Such an analysis should begin with the most basic of questions: Do we need to change from the eligibility regulations that presently govern the Indian Health Service. These regulations have, after all, served us well for more than 30 years. If Tribes determine there is indeed a need for change, they must be provided a full report as to how the various options will affect their people -- only then can they be expected to make an appropriate response.

NIHB believes that the strength of Senate Bill 2382 -- aside from the fact that it places a three-year moratorium on any changes in IHS eligibility guidelines -- is its requirement for a comprehensive study on revisions to IHS eligibility criteria, to be conducted in cooperation with Tribal governments. We are especially pleased that the bill calls for the study to examine not only the financial and demographic affects of such a change, but to consider the health status, cultural, social, and economic impacts on Indian individuals and communities as well.

NIHB believes that Senate Bill 2382 reflects the sentiment expressed by Tribal leaders and individual Indian health consumers about the IHS final rule on eligibility, and we urge this Committee to give the this bill its prompt consideration. We would also ask that the Committee consider the following additions to the bill, consistent with the resolution supported by Tribal representatives at the "Nashville '88" meeting:

1. Include language directing the Secretary of Health and Human Services to withdraw the September 16, 1987 final rule.

2. Include language that specifically establishes the existing IHS eligibility criteria in statute.

3. Require an indefinate moratorium (rather than three years) on the implementation of any new regulations, until such time that Congress approves the need for such change.

This concludes my remarks. Again, I wish to thank you for the opportunity to comment on this important bill. I would be happy to answer any questions you may have about my testimony.

APPENDIX: PART 1, B

IN SUPPORT OF CONGRESSIONAL INTERVENTION ON THE IHS ELIGIBILITY REGULATIONS

We the undersigned individuals, attending the 'Nashville 88" IHS/Tribal consultation workshop on health issues May 3 - 6, 1988, do hereby recommend and request that:

1) The Secretary of the Department of Health and Human Services withdraw the final rule on Indian Health Service (IHS) eligibility scheduled to go into effect in September 1988.

2) The Congress of the United States enact legislation during this session which would:

   a) Establish, by statute, the current eligibility criteria for IHS services.

   b) Require an indefinite moratorium on the implementation of any new regulations.

   c) Require IHS to conduct an Area-by-Area assessment of the impacts of various alternative changes in the IHS eligibility criteria, with full participation and consultation of American Indian and Alaska Native tribal governments in this process.

   d) Require IHS to provide a report to Congress and to tribal governments conveying this assessment, including the recommendations of tribal governments.

NAME	AREA	TRIBAL AFFILIATION
Ethel Lund	ALASKA (SEARHC)	TLINGIT
Henry SiJohn	Portland	[illegible] Coeur d'Alene
Jake L. Whitecrow	National	Quapaw / Seneca-Cayuga
Robert [illegible]	Alaska ([illegible])	[illegible] / Yupik
Danny [illegible]	Albuq	Zuni
Wendell Chino	Albuq	Mescalero Apache Tribe
Kay [illegible]	Albuq	Santo Domingo Tribe
Angelo Joaquin Sr.	Tucson - Phx	Tohono O'odham Nation

IHS Eligibility Regulations
Nashville 88 - May 3 - 6, 1988

STATEMENT ON S.2382, A BILL TO DELAY THE IMPLEMENTATION OF INDIAN HEALTH SERVICE ELIGIBILITY REGULATIONS

BY

EMERY A. JOHNSON, MD, MPH

Assistant Surgeon General, Retired
United States Public Health Service

BEFORE THE

SELECT COMMITTEE ON INDIAN AFFAIRS
UNITED STATES SENATE

JUNE 21, 1988

I am pleased to appear before this committee to present my views on S.2382, a bill to delay the implementation of Indian Health Service (IHS) eligibility regulations. For almost all of my 26 years of service in the IHS, I operated under the present eligibility regulations -- from my first assignment to the PHS Indian Hospital in White Earth, Minnesota through my 12 years as the Director of IHS. Since my retirement in 1981, I have continued to be actively involved with Indian health as a consultant to national and regional Indian organizations, American Indian and Alaska Native (AI/AN) tribal governments and other organizations with interests in Indian health. My views are based on those years of working under the current eligibility regulations as well as my present experience with the Indian health program and with tribal leaders, health staff (both IHS and tribal) and other experts in the field of health services delivery.

This committee through its oversight function has a vital role in assuring fair and equitable treatment of American Indian and Alaska Native people by the United States and in monitoring the activities of the Federal agencies in carrying out their responsibilities under Federal treaties and statutes. I believe that it is important to remember that it was the Congress, in 1954, that determined that the then status of Indian health was "appalling" and set us on the course we are on today. The Congress, as you stated in your June 14, 1988 letter to me, "established the goal of raising the health care status of Indian people and Alaska Natives to the highest possible level". To eliminate the disparity between the health status of AI/AN and that of the general United

BEST AVAILABLE COPY

States population, Congress selected the Indian Health Service to carry out that Congressional mandate. Together, the Congress and IHS realized that success was ultimately dependent on the full participation of AI/AN communities and their leaders and, through sound policies, increased funding and appropriate legislation, established the partnership that has demonstrated such success. It is now being recognized that truly remarkable progress has been made by the IHS and the tribal health programs in improving the health status of American Indians and Alaska Natives during the past three decades. However, many are now concerned that the proposed new eligibilty regulations threaten this progress and partnership.

In order to carry out the Congressional mandate to elevate AI/AN health status, IHS at the time of the transfer from the Bureau of Indian Affairs (BIA) in 1955 determined that improving access to and obtaining acceptance of modern health care service by the members of the American Indian and Alaska Native communities was essential. Any action that placed barriers to access and acceptance was considered, correctly, in my opinion, to impede the process of improving AI/AN health status. Therefore, the regulations were made as simple as were reasonably possible -- services were to be provided to persons "of Indian descent belonging to the Indian community served by the local facilities and program " (1956). Our understanding was that the term "Indian communities" meant those that were accepted at that time by the Bureau of Indian Affairs.

BEST AVAILABLE COPY

Over the years, additional Indian communities were added as they were identified as either "non-terminated" groups or as tribes given Federal recognition by Congress, the Federal Courts or the BIA Federal Acknowledgement Process. In general, then, the "Indian communities" referred to in the regulations were consistent with the concept of "Federally-recognized Indian tribes" and with Supreme Court decisions and Federal Indian legislation.

However, the term "belonging to the Indian community" was not clearly defined and did not, in fact, require a formal relationship such as "membership" in the tribe. At the time, the controlling Federal legislation for the Indian health program remained the Snyder Act, which "contains no express statutory language on who shall be eligible for Indian Health Service (IHS) services other than 'Indians throughout the United States'." (Office of Technology Assessment, 1986). It was our view in IHS that all members of the Indian family and of the "Indian community" would have to be served if the program goal to elevate the health status of AI/AN was to be achieved. To deny health services to certain individual members of an Indian family or "Indian community" on that technicality would have, in the program's opinion, presented an unacceptable barrier to access and acceptance and would be counter-productive to the Congressionally-mandated goal.

Following the Supreme Court decision in Morton v. Ruiz (1974), which struck down the BIA regulations that limited services to reservation residents, IHS revised its eligibility regulations for "Contract Health Services" (CHS) (services provided in non-IHS facilities but paid for by IHS) to require that otherwise eligible Indians could receive CHS services only if they met the additional requirements of residing "on or near" an Indian reservtion and maintained "close social and economic ties" with that reservation. Placing a more restrictive eligibility standard for CHS was considered to be consistent with the Supreme Court decision in Ruiz which stated, in part, "The power of an administrative agency to administer a congressionally created and funded program necessarily requires the formulation of policy and the making of rules to fill any gap left implicitly or explicitly by Congress". Since the major additional cost of providing an additional health service in an IHS facility ("direct service") is relatively small (e.g. drugs and medical, laboratory and x-ray supplies and, additionally for hospital inpatients, laundry and raw food costs) while a similar CHS service requires first dollar expenditure, it was our view that adding these restrictions only to CHS services was reasonable and consistent with the Congressional mandate to elevate AI/AN health status.

As time has passed, with the increase in the AI/AN population produced by relatively high birth rates, reduced AI/AN mortality, the addition of new

Federally- recognized tribes and the general escalation of medical care costs, including rapid advances in life-saving but frequently very high cost medical technology, along with Federal appropriations to the IHS which frequently have not even matched the level of inflation in health care costs, "the gap left implicitly or explicitly by Congress" has widened. That these improvements in health status have occured in spite of the continued AI/AN burdens such as poverty, isolation, educational deprivation and poor housing is all the more remarkable when it is realized that the IHS has been, for all of its more that three decades of service, RATIONING medical care. Every authoritative study of IHS that I have seen (from the Grace Commission to the Office of Technology Assessment) agrees that the funding provided to IHS is inadequate to meet the health services needs of AI/AN people currently served. For example, the Office of Technology Assessment study, Indian Health Care, in 1986 noted this "rationing" of health care and the Department of Health and Human Services (DHHS) Health Care Financing Administration has reported that per capita medical expenditures for Indians has declined by 25% from 1980 to 1987 and that the disparity with similar expenditures for the US general population has doubled during these years.

Based on these facts and on Congressional directives, e.g. in 1982, the House Appropriations Committee on the Interior stated that "IHS must address the issue of an expanding service population in determining who is or should be eligible for IHS services" (H.R. Rep. No. 97-942), it was, in my view, appropriate for IHS to consider revisions of its long-standing eligibility regulations. From the June 6, 1983 Federal Register solicitation of comments on eligibility options (48 FR 25273) through the notice of proposed rulemaking (51 FR 21118 et seq.) and the extension of the comment period (51 FR 36412), I believe that IHS made a good faith effort to address this issue and to involve the AI/AN tribal governments in appropriate consultation. However, when the Department of Health and Human Services published the final regulation, which was substantially different from the earlier proposed regulation, in the Federal Register on September 16, 1987 without submitting it to the expected tribal consultation process, the process was doomed to conflict and misunderstanding.

In discussions with a number of AI/AN leaders, I have been impressed by the major misunderstandings and confusion that surrounds the final rule. Over the past twenty years, we have found that there is no substitute for full and detailed consultation with AI/AN tribal governments BEFORE final decisions are made if there is to be reasonable acceptance of change. That truth was not followed in this instance - with predictable results. There is, in my view, no responsible alternative now but to retract the new regulation and to conscientiously pursue the essential consultation process with the AI/AN tribal governments.

In that process, it will be necessary to fully involve the AI/AN tribal governments in reconsidering the details of any proposed eligibility regulations and the impact that these changes would have on the health, cultural, social and economic status of AI/AN people, not just on the numbers of people affected or the monetary costs involved. Admittedly, the issues to be considered are complex but it is my view, again based on discussions with AI/AN leaders, that this consultation can be a most fruitfull effort and that there is the potential for some reasonable consensus.

One of the most difficult decisions to be made concern that of "tribal membership". While it is clear that AI/AN tribal governments have the authority to determine their members (Martinez v. Santa Clara Pueblo, 1978), strictly limiting health services to "members" raises other concerns. As noted earlier, denying health services to individual family members who, for one technicality or another, may not be a "member" could have an adverse impact on the health status of that family and on its AI/AN community and serve to frustrate the attainment of the Congressionally mandated goal of elevating the health status of AI/AN.

Additional problems are exemplified by Indians of California. Many California Indians were members of tribes whose treaties were never ratified by the United States and whose people were dispersed over many land bases. While I personally believe it is unwise to bestow eligibility to individuals based on descendency alone, which could undermine the concept of the government-to-government relationship between the AI/AN tribal governments and the United States, some process should be provided to allow these Indian people to be included in a Federally-recognized entity so that they may continue to receive IHS services.

History has demonstrated that real progress can be made in elevating the health status of American Indian and Alaska Native people through an effective partnership between the Federal and tribal governments and their respective health staffs. It is my view that the proposed new eligibility regulations do indeed threaten this partnership. The provisons of S.2382 will afford the tribes and IHS the opportunity to engage in the essential consultation that can result in a renewed commitment to this vital partnership. Congress has demonstrated its understanding of and commitment to this goal ever since the transfer of the Indian health program to the Public Health Service in 1955. I am confident that this progress will continue.

I would be happy to answer any questions that you have for me.

SENATE OVERSITE ON IHS ELIGIBILITY

Earl Old Person, Chairman
Blackfeet Tribal Business Council

Honorable Senator Melcher, my name is Earl Old Person, Chairman and Chief of the Blackfeet Tribe. On behalf of the people of the Blackfeet Reservation, I would like to submit written testimony supporting your proposed legislation or Senate Bill 2382, a bill to delay the implementation of the I.H.S. eligibility rule under which Indians are eligible to receive health care.

I would like to begin my testimony by thanking you for the concern and support that you have shown throughout the planning and construction of the Blackfeet Community Hospital.

The Blackfeet Tribe would like to request that your bill include a provision to assist the Indian veteran in obtaining health care through the Indian Health Service for Contract Health Services. The Council supports Indian Health Services attempts to utilize all existing forms of funding for Health Care, except for the requirements of shipping our Indian Veteran's to the V.A. Hospital located several miles away from the reservations. This creates a financial hardship on not only the patient, but on the families, as they are unable to travel these great distances to be with each other.

However, we think that the Eligibility Final Rule as published by the Department of Health and Human Services in the Federal Register on September 16, 1987 should be withdrawn in its entirety.

We believe that an impact study needs to be done on the effects of such a ruling as set forth in 42 CFR Part 36. The ruling creates effects that cause some of our people to lose benefits or health services and some to be added if the Tribe changed the enrollment criteria.

The Eligibility Final Rule has created much chaos on the Blackfeet Reservation. Our Tribe over the years has discussed enrollment criteria--on who is a member and who is not a Tribal member. We recently established an Ad Hoc Committee of Tribal members to study and hold community meetings on the issue of enrollment. The IHS Eligibility Rule was the overwhelming issue that people were concerned about. If any issue has caused disruption, factions and arguments the Eligibility Rule has taken precedent. It has caused our people to take sides: Full bloods against breeds; breeds against non enrolled Indians; Tribal descendents against full bloods; etc. If the intent of this rule was to stir up Indians then it certainly has caused that and more. Some factions have developed into almost formal organizations and revolutionary criticisms and statements are being made.

Although we will take responsibility for determining who is Blackfeet, we certainly don't need the government to tell us who is going to live and who is going to die! And the Eligibility Rule does split families and determines who gets health care and who does not. Although this may sound dramatic the effect of the Rule is more than possible. A Blackfeet descendant could die because of the lack of health care and another could live because they were in right federal category.

There has been a lot of information and misinformation on the Eligibility Rule. If the Tribe increased it's enrollment, would federal funding and services be increased? Is the Rule developed with the intent of reducing costs and therefore health services to Indians?

One thing we do know is that our health status is still below that of the general American citizen. We don't live as long; our babies die; alcoholism, accidents, and injuries are much more prevalent then the dominant society. We suffer from diabetes, respiratory infections, and ear infections at a rate that far outstrips the national average.

If we can't get adequate services for our existing population, why change the rules.

We believe that a change in eligibility needs to be analyzed from an overall Tribal perspective. Can you be a Tribal member for land ownership but not for health services? Is the government going to ration health care as it did with food when we starved to death in the late 1800's?

We believe this whole issue of eligibility needs to be analyzed at the reservation level too. Government officials need to sit down with Tribal governments to study these kinds of issues. Cost factors, cultural, family, economic, social and other areas need to be reviewed before action is taken on who receives health services in Indian country. Impacts on other agency and government services needs to be reviewed, such as the BIA, State welfare land social services, Medicare and Medicaid, Veterans benefits etc.

The Blackfeet Tribe is thankful to you for the continued support you have shown us concerning the completion of the Blackfeet Treatment Center that is under construction. In attempts to complete this facility and obtain our desired goals we need to ask that your office assist us in acquiring additional funds in the amount of $313,000. Also support is needed for competent Medical Staff to operate this facility.

Sincerely,

Earl Old Person

TESTIMONY OF THE EASTERN BAND OF CHEROKEE INDIANS
AND TRIBES OF THE UNITED SOUTH AND EASTERN TRIBES, INC.
ON THE PROPOSED SENATE BILL 2382
INDIAN HEALTH SERVICE ELIGIBILITY RULE

SUBMITTED TO THE SENATE SELECT COMMITTEE
ON INDIAN AFFAIRS

JUNE 21, 1988

TESTIMONY OF JONATHAN L. TAYLOR, PRINCIPAL CHIEF

Mr. Chairman and Distinguished Members of the Senate Select Committee on Indian Affairs, I am Jonathan L. Taylor, Principal Chief of the Eastern Band of Cherokee Indians. I wish to thank you for the opportunity of appearing before you today. My Tribe is comprised of approximately 10,000 Native Americans and our reservation is located in the western part of the state directly adjacent to the Great Smoky Mountain Nation Park.

I am here today to provide and comment on the proposed bill to delay the implementation of a certain rule affecting the provision of health services by the Indian Health Service - Senate Bill 2382, introduced by Senator Melcher.

I am here to testify on behalf of the Eastern Band of Cherokee Indians and on behalf of the other seventeen member Tribes of the United South and Eastern Tribes, Inc. (U.S.E.T.) This organization is an inter-tribal organization which represents federally recognized Native American Tribes from Maine to Florida and West to Louisiana.

All my concerns and beliefs expressed here today are shared by the vast majority of Indian people throughout the nation as we face the critical task of providing quality health care to our people.

Mr. Chairman, let me state that we, the Cherokee people and members of U.S.E.T., support Bill 2382. We feel this legislation will effectively put a "hold" on the implementation of the Eligibility Rule which was published on September 16, 1987. The Bill would enable both the Federal Government and Native American Tribal governments to more fully and accuratley assess the impact of this rule and any other changes in eligibility provisions. Senator Melcher's bill recognizes the government-to-government relationship involved with Indian Tribes by requiring "full participation and consultation with American Indian and Alaskan Native Tribal Governments and representatives of urban Indian health care programs" in the impact study. Also, this proposed study will address the many complex issues and concerns that are involved with eligibility for Indian health care services. The most important being that accesssible, quality health care is critical to the survival of Indian people - and it is a trust responsibility of the U.S. Government.

Mr. Chairman, I would like to briefly present some of the concerns that the Cherokee Tribe and the U.S.E.T. Tribes have regarding the Eligibility Rule.

First, Mr. Chairman, I would like to note that we have been concerned about and involved in this issue long before the Rule was ever published. Eligibility for Indian health care services affects the very heart of Tribal Government. Tribal leaders have long maintained that any policy regarding eligibility must be made with the full participation and consultation of the Tribes.

During the Annual U.S.E.T. Board Meeting held on February 18, 1988, which was held during "Impact Week," U.S.E.T. unamiously passed Resolution B-88-195. This Resolution, of which a copy is attached for your records, clearly states that the U.S.E.T. Inc., opposition to the Final Rule of September 16, 1987 and calls for many of the measures proposed by the legislation we are addressing today - Senate Bill 2382. Additionally, the U.S.E.T. Tribes participated in the Nashville '88 meeting which resulted in another resolution requesting Congressional intervention in the proposed eligibility regulations. This resolution was signed by representatives of Tribes throughout the nation.

Our concerns regarding the Eligibility Rule focus on both the "process" by which it was developed and the "specifics" of the Rule.

Number 1:

The process by which the Eligibility Rule came about was contrary to the government-to-government relationship which should exist with Indian Tribes. There was little-to-no consultation with the tribes before the Notice of Proposed Rule Making. The Final Rule included specific items which were not included in the Proposed Rule Making announcement. Although the comment period was extended, it offered limited opportunity or information for Tribes to accuratley determine the possible impacts they would have to face and make comment on the proposed Rule. Indeed, one of the problems still facing the Tribes is a very lack of information on how this Rule will affect them.

Number 2:

There are virtually NO assessment study analysis on how this Rule would impact the Indian people before it was published. The burden of determining such impact has rested upon the Tribes. Some I.H.S. Area Office staff have provided data and/or projections on an area or tribal basis but this has not been comprehensive or consistent. It is unconceivable that a regulation so crucial to the health status of Indian people would be implemented without such prior analysis of impact. Furthermore, it has become clear that there has been only limited post-publication analysis of the Rule's impact. Even after Congress imposed the current six month moratorium, the Indian

Health Service has not reported on the comprehensive affect of the Rule, either to Congress or the Tribes. There are too many questions left unasnwered about the Rule.

Number 3:

As far as the specifics of the proposed Eligibility Rule is concerned, it is clear that the Rule will have varying impacts upon the extent and quality of health care services for Indian people. This is true for the U.S.E.T. Tribes and nationally as well. While many specifics are unknown, some - for U.S.E.T Tribes - have come to light:

A. The Rule will make many Indian people ineligible for services. For example, those Indian people who choose not to enroll themselves as Tribal members because of political, religious, cultural or personal reasons. This is the case for "Independent" Miccosukees and Seminoles in Florida and many "Traditional" St. Regis Mohawks in New York. It should be emphasized that the people referred to are members of the community, and in all aspects except enrolled status, otherwise participate in Tribal activities, economy, cultural and customs.

Such a loss of eligibility for health care services will result in other areas of the nation as well. In Alaska, it is estimated that as much as 15 percent of the current service population would be disqualified for health care services under the Rule as there is no process in place that accurately records federally-recognized Alaskan Natives.

B. Some Tribes base their membership along matriarchal lines. Thus, adult children whose fathers are a member of the Tribe but whose mothers are not, will not be eligible for services, despite their Indian descendency and participation in the Tribal community.

C. Some U.S.E.T. Tribes will be forced to deny services to previously eligible community members and extend the very same health services, direct and contract care, to members of other federally-recognized Tribes who live within their service area, but do not participate in their community, politically, socially, culturally or eonomically.

This is the case of the Miccousukee and Seminole Tribes, the Seneca Nation in New York and for my Tribe, the Eastern Band of Cherokee Indians in North Carolina. Indians from other Tribes have come to these areas seeking employment but do not participate in or become a part of the Indian Tribal Community.

D. The Poarch Band of Creek Indians in Alabama will experience a dramatic change under the proposed Rule. It is estimated that the demand for health care services could possibly increase by almost 100 percent, due to the eligibility of Non-Poarch Indians living in their service area. This will severely limit the resources of the Poarch Band to provide adequate care, and

E. Almost 500 Choctaw Indians in Mississippi will be refused health care service under the provisions of this regulation.

Number 4:

Mr. Chairman, the U.S.E.T. Tribes are concerned about the impact of this regulation of the health status of Indian people. Over the past few decades, tremendous progress has been made in elevating the health status among Indians. Tribal leaders are concerned this progress will be stagnated. The health of Indian People is at risk! What will become of those who previously received health care services when they are no longer eligible? According to the Rule, they must seek "alternate resources." Presumably, this means federal, state, county or private programs for health cost coverage. Most public programs are already hard-pressed to provide services. Indian people often can't afford either private insurance programs or to pay for health services. Are Indian people, once again, to be put at the bottom of the list for basic health care?

Most Indian people affected by this regulation live in remote areas served primarily by I.H.S. or Tribal contractors. What will be done to ensure adequate delivery of health care services to those people who would no longer be eligible for I.H.S. services? Especially, when the nearest public or private health care facility - not and I.H.S. facility - is many miles away and they do not have adequate transportation, if they are elderly or if they are handicapped? Mr. Chairman, how will these people be served?

Additionally, in service units where the eligibility client population is increased, there is concern that scarce resources (financial, staff, facilities) will be spread even more thinly than at present. There appears no guarantee that added clients will be served by added resources. Tribal leaders are concerned that many health care services which fall into the "preventive" category will be foregone in order to provide treatment to an increased client number. Programs involving health education, home visits and personal care may be time consuming and labor-intensive but they have proven successful among our people. Such programs must not be sacrificed.

Service units experiencing a decrease in eligibile clients are concerned that their operating budgets will be reduced accordingly, despite effective performance and progress in health care delivery. Some Tribal leaders are fearful that the result will restrict health services to the "urgent and emergent" level on a continuing basis and end the decades of progress in Indian health care. Such a situation, while dismal, is even more threatening when we consider the future health status of our children who may grow up without adequate health education. The time and money we invest, or fail to invest, will become evident in our communities tomorrow.

Number 5:

The issue of Indian health care funding cannot be ignored. Tribal leaders are extremely aware of the ever-increasing pressures placed upon the federal budget. Indeed, many tribes have already sought additional funding sources, public and private to support their health care delivery systems. Alternate resources are identified wherever possible to offset the burden placed upon I.H.S. funded services. Tribes have also contributed resources from their own funds and from their economic development revenues to ensure that their people are provided adequate health care. Still, many programs experience budget over-runs; most struggle annually to keep within budget and funding parameters. The Cherokee Indian Hospital on my reservation is just one example. Each year we fight to keep on budget but health care needs and health costs are increasing faster than funding and the result is that we do not have enough money for the whole year. Tribal contract programs experience the same problem.

In light of these efforts, it is unacceptable to ask Indian people to risk their health so that arbitrarily-determined national budget figures can be obtained. The burden of balancing a federal budget must not be placed upon the shoulders of young children and the elderly. Once again, the federal responsibility for Indian health care is not debatable and must not be compromised.

These comments are made to explain more fully the position of the U.S.E.T., Inc. Tribes on a regional basis. Other U.S.E.T. member Tribes may wish to express additional, more Tribal-specific concerns as to the impact of the Eligibility Rule upon their health systems. For some Tribes the impact may even be marginal due to their existing service are size, membership criteria and other factors. Still, their concern is substantial because of the uncertainty of future regulation changes and the manner in which such changes are being made.

Mr. Chairman, I would like to thank you, Senator Melcher and other members of the Committee for the support you have given Indian people. I am confident that the Committee will recommend Senate Bill 2302 favorably and this pending disaster for Indian health care can be avoided. I hope, in the future, federal policy initiatives towards Indian health services will involve Tribal leaders. It becomes painfully more evident with each policy action pursued by both I.H.S. and the B.I.A., that a truly meaningful consultation process would be mutually beneficial and more consistent with the sovereign rights of Native American Tribes.

In closing, Mr. Chairman and Distinguished Members, I would like to extend my appreciation to you for providing me the opportunity of presenting this testimony. On behalf of the Eastern Band of Cherokee Indian and the United South and Eastern Tribes, Inc., we truly appreciate all assistance and concerns given in the health care provided to all Indian people and we look forward to working with you in the future.

UNITED SOUTH AND EASTERN TRIBES, INC.

Resolution No. B-88-195

WHEREAS, the United South and Eastern Tribes is an inter-tribal Council composed of seventeen federally recognized tribes in the Eastern United States; and

WHEREAS, one of the principle goals of the organization is to improve the health status of Indian people; and

WHEREAS, the Board of Directors is aware of the new requirements for eligibility for Indian Health Services as published in the Federal Register, September 16, 1987; and

WHEREAS, the member tribes are extremely concerned about the potential negative impact of these new regulations with regard to increased demands on health systems and the denial of services to currently eligible individuals; and

WHEREAS, further concern exists concerning the process by which the rule was promulgated, specifically, without complete analysis by Indian Health Service and input from tribes.

NOW, THEREFORE, BE IT RESOLVED THAT the Board of Directors of United South and Eastern Tribes calls for a moratorium to be placed on the implementation of the eligibility regulations until such a time that an in-depth analysis of the impact of these regulations can be completed; and

BE IT FURTHER RESOLVED THAT Indian Health Service initiate an ad hoc committee be formed with representation from both Indian Health Service and tribal groups to prepare the analysis that will address, at a minimum, the following issues: coverage of Indian people; implications with regard to RAM, SURAM, and ARAM issues; and the questions of sovereignty and the rights of tribes to determine its membership; and

BE IT FINALLY RESOLVED THAT the results of this analysis be presented to Congress and be reviewed by appropriate committees in open session, and that the analysis will be used in the formation of revised eligibility requirements, if needed.

CERTIFICATION

The above resolution was duly passed at the Board of Directors meeting, at which a quorum was present, in Washington, D.C.; February 16-18, 1988.

Joel M. Frank, President
United South & Eastern Tribes, Inc.

Harold Tarbell, Secretary
United South & Eastern Tribes, Inc.

Statement of Assiniboine and Sioux Tribes of the Fort Peck Reservation concerning S. 2382, to delay the implementation of proposed changes in the eligibility requirement of the Indian Health Service

before the

Senate Select Committee on Indian Affairs

June 21, 1988

Raymond White Tail Feather,
Chairman
Assiniboine and Sioux Tribes of
The Fort Peck Reservation

Statement of Assiniboine and Sioux Tribes of the Fort Peck Reservation concerning S. 2382, to delay the implementation of proposed changes in the eligibility requirement of the Indian Health Service before the Senate Select Committee on Indian Affairs

June 21, 1988

The people of the Assiniboine and Sioux Tribes of the Fort Peck Reservation thank you for the opportunity to include this testimony in the record of the hearing on Senator Melcher's bill, S. 2382. This bill would impose a three-year moratorium on the proposed changes in the eligibility requirements for the Indian Health Service. We also thank Senator Melcher for introducing the bill and appreciate the Select Committee's swift consideration of this important measure.

The mission of the Indian Health Service is to provide the best possible health services to American Indians, a group which suffers the lowest health care status of any ethnic group in the United States. Consistent with this mission, eligibility criteria in the past have enabled the IHS to serve entire Indian families and communities. This permits a well-coordinated approach to solving health problems in the community and promotes consistent, high quality health care within individual families.

Yet the proposed eligibility criteria, by unfairly narrowing the definition of Indian, without regard to the needs IHS is supposed to serve and the extent to which the Indian population is affected, seem designed more to reduce the number of Indians eligible to receive medical care than to fulfill the basic mission of IHS. In recent years, IHS has appeared to be more interested in saving money for the government than in helping the Indian people. Instead of asking Congress for more money so it can improve Indian health care, IHS asks for less money practically every year. This year, it requested an increase well under the rate of inflation. The eligibility proposals are part and parcel of this same approach -- cut the budget to the bone, cut down the number of recipients, and provide only the most basic health services.

Equally disturbing is that despite the extra time afforded by the Congressionally-imposed delay of the first proposed regulations, IHS continues to be ignorant of the effects on the Indian population. The budgetary and program impacts have not been analyzed. No study has been conducted on the human impact of these measures. No one knows how many Indians will lose health care services and will be left without alternatives. It makes no sense to implement these regulations without answers to questions about their impact.

For instance, one group of Indians comes to mind who would be unfairly cut off from receiving IHS health care services. We have many Indians living on the Reservation who have blood of several tribes. Some, although undeniably Indians, do not have enough blood of any one tribe to be a tribal member. Under the new eligibility proposals, such Indians may not have enough blood to qualify for membership in one of our tribes, but would be eligible for membership and IHS health services under the new rules if all of their blood were of one tribe. This is ridiculous. It is also offensive, because many Indians of different tribes ended up on the same reservation due to the United States' policies toward Indians during the nineteenth century. IHS now seeks to deny eligibility to individuals who are the products of the federal government's own policies.

We are also concerned about the children of tribal members who are not eligible for membership due to blood quantum. These children would be eligible for IHS services under the new rules only until the age of majority, 18, after which they would be ineligible. These children, regardless of age, are part of our Indian community. Many live on the Reservation for their entire lives. We believe that to ensure a consistent, well-coordinated approach to health care in our community, and for the good of the community in general, these individuals ought to be eligible even after the age of majority just as they are under the current rules.

Three steps need to be taken to resolve fairly the issue of eligibility requirements. First, as wisely proposed by Senator Melcher, the Congress should swiftly move to delay the implementation of the regulations for three years. Second, in this time period, as Senator Melcher's legislation provides, a full impact study must be undertaken of the new IHS eligibility rules (or any other proposed new eligibility criteria) with full Native American participation and consultation. At the Nashville 88 meeting of tribal leaders, representatives of more than 75 tribes voted unanimously in opposition to the new eligibility rules and in favor of such a study.

Finally, the third step to be taken is that IHS must rethink its approach to eligibility criteria to respect the sovereignty of the tribes and to account for the differing views of the tribes on these matters. Many tribes -- probably most -- would agree with the views we have expressed. Some, of course, may not. Some may approve of the IHS criteria, others may feel entirely different standards are appropriate. This is not surprising, because due to the past policies of the federal government, geography, and other factors, the make-up of the Indian community varies widely from reservation to reservation. It is the position of the Fort Peck Tribes that each tribal government, within groundrules set by IHS, ought to be able to establish the eligibility requirements for its own reservation.

At Fort Peck, we would adopt the following requirements. We would make all Fort Peck tribal members eligible for IHS services. We would make children of tribal members eligible where they reside on the Fort Peck Reservation and maintain close social and economic ties with the Fort Peck Tribes. And finally, Indian people who do not meet the above requirements would be eligible if they reside on the Reservation, maintain close social and economic ties with the Fort Peck Tribes, and have at least one-eighth blood of any tribe.

The Fort Peck Tribes urge that IHS use the three-year moratorium constructively, to drop its unreasonable proposal, study the problem more carefully, and permit tribes to determine eligibility on their own reservations within certain guidelines. If IHS insists on adopting a uniform set of eligibility requirements, we urge it to adopt those we have proposed. Individuals must not be unfairly dropped from the eligibility rolls in order to save a few dollars for the federal government.

Respectfully submitted,

Raymond White Tail Feather
Chairman
Assiniboine and Sioux Tribes of
the Fort Peck Reservation